State Served	[1]No. of Transactions	[2]Approximate Annual Recoveries (millions)	[3]Medicaid Net Expenditures (billions)
Kansas Department of Social and Rehabilitation Services	943,066	$11.9	$0.8
Louisiana Department of Health and Hospitals	2,207,424	$18.1	$3.1
Massachusetts Executive Office of Health and Human Services	1,821,083	$13.3	$4.4
Maryland Department of Health and Mental Hygiene	965,838	$13.1	$2.5
Maine Department of Human Services	86,474	$2.5	$1.1
Michigan Department of Community Health	447,581	$9.4	$4.7
Missouri Department of Social Services	3,061,103	$20.0	$3.5
New Jersey Department of Human Services	5,580,110	$79.6	$3.9
North Carolina Department of Health and Human Services	779,499	$20.7	$5.9
New Mexico Human Services Department	186,184	$2.7	$0.7
Nevada Department of Health and Human Services	175,207	$5.8	$0.6
New York Department of Health	2,729,520	$110.4	$22.4
Ohio Department of Job and Family Services	8,783,883	$20.0	$7.6
Oklahoma Health Care Authority	705,807	$6.5	$1.7
Pennsylvania Department of Public Welfare	3,006,258	$28.5	$6.1
Tennessee, Bureau of TennCare	2,863,206	$6.1	$3.4
Texas Health and Human Services Commission	3,073,268	$47.7	$8.7
Virginia Department of Medical Assistance Services	1,520,659	$15.7	$2.2
West Virginia Department of Health and Human Resources	63,709	$1.6	$1.3

[1] Reflects 2007 TPL billed transactions
[2] Recoveries for all TPL-related services including case management and program integrity projects
[3] Expenditures covered by third party payors based on the most current available expenditures from CMS (2004)

4.2.7.5 Services Timely Provided and Within Budget

Identify if the services were timely provided and within budget.

As our references can attest, HMS approaches each project with a practical methodology that emphasizes thorough planning, definition of requirements, accountability, and client input and approvals at several points throughout the process. As a result, HMS consistently achieves project milestones, including timeliness and quality of deliverables, as well as operating within established budgets.

HMS's Effective Service Solutions

HMS's history of fulfilling contract requirements in a timely and cost-efficient manner is backed up by our high client retention rate, track record of achieving record results year after year, and exhibiting remarkable corporate growth.

Exhibit 4.2.7-F highlights our successful track record performing timely implementations—and also demonstrating our history of achieving significant economies of scale. Note that since most HMS contracts are contingency-fee based, HMS assumes responsibility for the costs associated with implementing our solution; as a result, the on-budget nature of these engagements is transparent to the HMS client agencies that benefit from their functionality and their results.

Exhibit 4.2.7-E: HMS has an impressive track record of implementing our customized solutions of varying complexity on time for our government clients

State	Project	Product	Month/Year
Alaska	Third Party Liability (TPL) identification and health insurance billing and recoveries	Cost avoidance, health insurance billing and recoveries, credit balance, HIPP, overpayment projects	January 1990
Idaho	TPL identification and health insurance billing and recoveries	Cost avoidance, health insurance billing and recoveries, credit balance, overpayment projects, casualty	June 1998
Iowa	Iowa *hawk-i* SCHIP	COB*Match* implemented for daily applicants and quarterly enrollee matches to identify other insurance	January 2007
Iowa	Iowa Medicaid Enterprise (Total TPL Outsourcing)	-All Third Party Liability Identification and Recovery functions, cost avoidance, health insurance billing and recoveries, estate recovery, lien recovery, provider overpayment adjustments, tax offsets, and Miller Trust recoveries -Implementation of eCare, Referral Database, Maestro, and Provider Portal	July 2005
Florida	Total TPL Outsourcing	All Third Party Liability Identification and Recovery functions (including, cost avoidance, health insurance billing and recoveries, casualty and estate recoveries) and many Overpayment Projects	November 2001
Pennsylvania	Pennsylvania Cover All Kids (SCHIP)	COB*Match* implemented for daily applicants and quarterly enrollee matches to identify other insurance	March 2007
Michigan	Joint Family Independence Agency and the Department of Community Health locate and verify insurance	Cost Avoidance performed for Medicaid and Medical Support Enforcement agencies, Casualty Recovery, processing National Medical Support Notices, and Hospital Audits	October 2004
Nevada	TPL Services	Cost avoidance, health insurance billing and recoveries, credit balance, HIPP, overpayment projects, casualty	June 2004
New Jersey	COB*Match*	-COB*Match* -Third Party Liability Identification and Recovery functions	COB*Match*-2007 All other-1994
Nevada	TPL Services	Cost avoidance, health insurance billing and recoveries credit balance, HIPP, overpayment projects, casualty	June 2004
North Carolina	TPL Services	Cost avoidance and health insurance billing and recoveries	2005
Oklahoma	TPL Services	All Third Party Liability Identification and Recovery functions	January 2005
Tennessee	TPL Services	Cost avoidance, health insurance billing and recoveries, estate recovery,	2006
West Virginia	WV SCHIP	COB*Match*	January 2008

HMS has developed a very successful track record of providing service and system solutions to our healthcare program clients, quickly conceptualizing and developing them, implementing them, and generating meaningful results early in the process. Our ability to concurrently manage multiple contracts is testament to our ability to achieve the same efficiencies on behalf of the Iowa ***hawk-i*** program.

4.2.7.6 Letters of Reference

> Letters of reference from three (3) previous clients knowledgeable of the bidder's performance in providing services similar to the services described in this RFP and a contact person and telephone number for each reference. The bidder shall not include references from the Iowa Department of Human Services.

With more than 34 years of experience performing healthcare-related services in over 40 states, HMS has demonstrated our ability to apply innovation and best practices in order to fulfill complex project goals. All HMS clients can attest to our:

- In-depth knowledge of the SCHIP and Medicaid programs, Enrollment Services and Eligibility Determination
- Dedicated staff—including Program Managers—available to serve clients
- Ability to comply with HIPAA and other security and privacy regulations
- Excellent customer and stakeholder service
- Data processing capabilities

HMS encourages the Department to contact our clients and inquire about our commitment and dedication to exceeding contract requirements. We have provided letters of reference from the following clients at the end of this section:

- Florida Department of Health
- Kentucky Cabinet for Health and Family Services
- West Virginia Department of Health & Human Services, Bureau for Medical Services

As well, the Commonwealth of Massachusetts forbids providing written letters of reference, but they are permitted to act as a reference and provide feedback verbally. Therefore, the Department can contact the following individual to discuss our client service results within Massachusetts:

Bill Connors, Director of Revenue Operations
Center for Health Care Finance
Commonwealth Medicine
University of Massachusetts Medical School
The Schrafft Center, Third Floor
529 Main Street
Charlestown, MA 02129
Telephone: 617 886-8165

4.2.8 Personnel

Throughout our history, HMS has successfully attracted and retained talented associates to support our clients. HMS has leveraged this expertise to implement the systems and services defined in the RFP and to support the Department under the contract. We already have a Des Moines-based team ready to begin upon contract execution who will be dedicated to the successful implementation and operations of the ***hawk-i*** program. This team will have the full resources of our technical and client services support teams in our corporate office, National Service Centers, and regional offices throughout the United States.

Our Focus on Customer Service

The cornerstone of HMS's personnel plan to serve the Department, applicants and enrollees of the *hawk-i* program is our Des Moines-based team. This team features seasoned leadership, SCHIP experience, and the dedication to customer service excellence that has been the hallmark of HMS's success.

HMS has more than sufficient administrative staff and organizational resources to ensure our compliance with contractual obligations. Including staff members of HMS and our parent, HMS Holdings Corp., HMS has access to the resources of **742 full-time personnel** with expertise in healthcare information management. These individuals are spread throughout the country to better serve our clients:

- HMS's New York City headquarters houses 244 personnel, all of whom focus on activities supporting our current 40 state Medicaid agency contracts, including related data support and administrative functions.
- Our National Service Center in Dallas houses 134 people, who focus on new IT development, Web-based infrastructure, and high-contact support activities (e.g., provider relations, eligibility determination, claims collection and follow-up) associated with our client contracts.
- The remainder of employees work in regional satellite offices perform account management and various support activities related to specific agency contracts.

Most of the HMS staff members who are proposed to support the ***hawk-i*** contract are located in the Des Moines service center, which we will establish immediately upon contract award. **John Davis**, HMS's Des Moines-based Project Manager, currently oversees our existing contract work with the Iowa Medicaid Enterprise and resides in the Des Moines area. Mr. Davis brings a wealth of healthcare operational experience to this role and is well-respected within the Department based on his management on the IME contract and his work with the ***hawk-i*** **COB***Match* project.

HMS Program Director **Pam Moores** currently directs both the ***hawk-i*** **COB***Match* project to identify other insurance for program applicants and enrollees, and our work for the Iowa Medicaid Enterprise. Ms. Moores also has over 12 years of experience working with the state of Colorado in various roles, including Quality Assurance Administrator, Third Party Resources Manager, and IT Contracts and Monitoring Manager, where she served as the liaison between the Medicaid and SCHIP agencies.

Robert Britton will serve as HMS's Implementation Manager. As a former Senior Vice President for MAXIMUS, Mr. Britton was responsible for SCHIP and Enrollment Broker Operations in California, and led teams in Texas and British Columbia to improve project performance, improve operations, and increase client satisfaction. Considering Mr. Britton's depth of experience in developing and running

SCHIP enrollment-related projects, we are confident in his abilities to successfully lead our implementation for the ***hawk-i*** engagement. Mr. Britton's knowledge of MAXIMUS's operations and systems will enable a smooth transition of the ***hawk-i*** administrative services from MAXIMUS to HMS.

Ensuring Smooth Transition for IME

In naming John Davis as the *hawk-i* Project Manager, HMS is taking steps to ensure that the success of our existing projects for the Department are not adversely affected. We have already begun screening potential replacements who match Mr. Davis's qualifications and management experience. Given the in-depth knowledge of DHS programs that Mr. Davis and several other HMS personnel maintain, we can expedite a smooth transfer of knowledge to ensure no impact to IME or *hawk-i*.

Working with Mr. Britton and leading our ***hawk-i*** implementation operations efforts will be **Cynthia Jones**. As the former Program Director for the ***hawk-i*** **COB***Match* project, and for the Iowa Medicaid Enterprise, Ms. Jones' brings both implementation and operations expertise to the team. Ms. Jones was recently promoted to Director of our Enrollment Services team. She will be heavily involved in developing systems and operational solutions for all of our enrollment offerings, including the ***hawk-i*** engagement.

Our employee base includes experts in healthcare and public policy administration as well as health insurance—including enrollment and premium processing, data processing, information management, Medicaid and SCHIP law and regulation, clinical review, claims coding, claims processing, and support operations. All staff work together to formulate and implement innovative solutions that enhance revenue and decrease administrative costs for HMS clients.

4.2.8.1 Table of Organization

Provide a table of organization. Illustrate the lines of authority. Include the names and credentials of the owners and executives of your organization and, if applicable, their roles on this project. Also, include key personnel who will be involved in providing implementation and ongoing services contemplated by this RFP.

We have assembled a team of dedicated personnel to fulfill the requirements of this contract. The team includes subject matter specialists in every operational area needed to deliver compliant, successful TPA services for ***hawk-i***, including: project management; implementation; customer service; application processing and eligibility determination; premium collection, capitation payments, and accounting; appeals; surveys; handling mail; information technology; quality assurance; and other allied functions. Although HMS's Des Moines-based team will be the core service team for this contract, they will have access to the technical, administrative, and management resources of HMS to ensure that we meet and exceed contract requirements.

HMS's Team Includes a Former Idaho SCHIP Administrator

HMS's Marnie Basom will be a Project Advisor for the *hawk-i* contract. As the Idaho Medicaid Children's Program Manager, she was responsible for the management and oversight for the Idaho CHIP, school-based services, and EPSDT programs. HMS will rely on Ms. Basom's expertise during both implementation and ongoing operations.

To show the Department how we plan to structure lines of authority (reporting relationships) among project personnel, and how our project personnel fit within the HMS organization, we provide the following exhibits:

- **Exhibit 4.2.8-A shows HMS's corporate organizational structure**. Executives, managers, and staff who will be involved in ***hawk-i*** administrative

services project operations are highlighted in blue boxes. HMS, Inc.'s parent company—HMS Holdings Corp.—is publicly held, and none of our executives holds a substantial ownership share in the Company.

- **Exhibit 4.2.8-B shows the *hawk-i* team structure**. This organization chart identifies the Project Manager (as well as the Implementation Manager and Systems Manager), shows how we propose to structure the functions of the project, and specifies the number of staff we propose to perform each function. We will provide an updated organization chart to the Department on a monthly basis, identifying any staffing changes within that month.

SCHIP Implementation Expertise

Robert Britton—a former MAXIMUS executive who was the Senior Vice President responsible for SCHIP and Enrollment Broker Operations in California—will lead HMS's implementation team.

4.2.8.2 Resumes of All Key Personnel

Provide resumes for all key personnel, including the project manager, who will be involved in providing the implementation and ongoing services contemplated by this RFP. The resumes must include: name, education, and years of experience and employment history, particularly as it relates to the scope of services specified herein.

Below we provide summary qualifications about the key HMS personnel who will implement and oversee the **hawk-i** TPA engagement, including their project roles.

Pam Moores, Program Director

As the Program Director for HMS's contracts in Iowa, Ms. Moores will work closely with our onsite Project Manager to assure attainment of contract requirements. An experienced engagement manager, she will regularly visit the local project office in Iowa to apply her substantial operations experience and ensure that performance goals are met. She will maintain close day-to-day contact with the Project Manager and operations team, working closely with them to leverage local project and staff resources effectively to assure optimal customer service. As necessary, she will also coordinate with senior project management (Kim Glenn, Senior Vice President of Government Services; and David Dawson, Midwest Regional Executive) to obtain and apply HMS corporate resources to meet and exceed project requirements.

John Davis, Project Manager

As the Project Manager, Mr. Davis will provide leadership, program oversight, and operations management. He is also the Department's primary liaison with HMS for this contract. As onsite Project Manager, he will work closely with the Operations Manager—coordinating and leading local project and staff resources to ensure that office performance goals are met or exceeded and a high level of service is delivered to all customers. Mr. Davis's major duties include:

- Ensuring that contract deliverables are accurate and delivered to the Department in a timely manner

Leadership Experience = Iowa Success

Together, HMS's Program Director Pam Moores, Project Manager John Davis, and Implementation Manager Robert Britton have 93 years of leadership, healthcare, SCHIP, and/or Iowa-specific experience that will facilitate a smooth transition from MAXIMUS and ensure that we meet, if not exceed, all contractual operational objectives.

Exhibit 4.2.8-A: HMS Inc.'s Corporate Organization Chart, Identifying HMS Executive and Other Personnel with Involvement in hawk-i Administrative Services

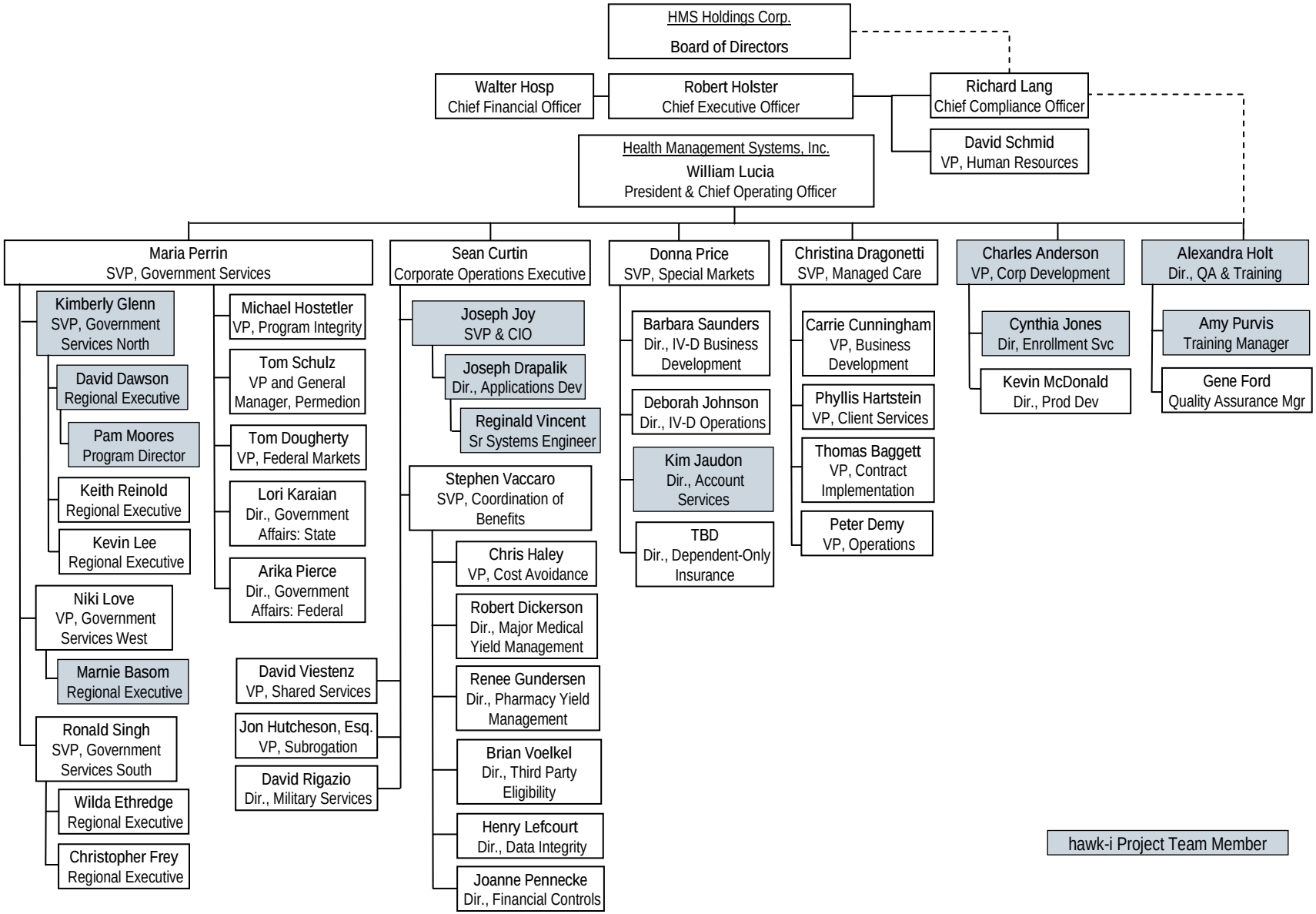
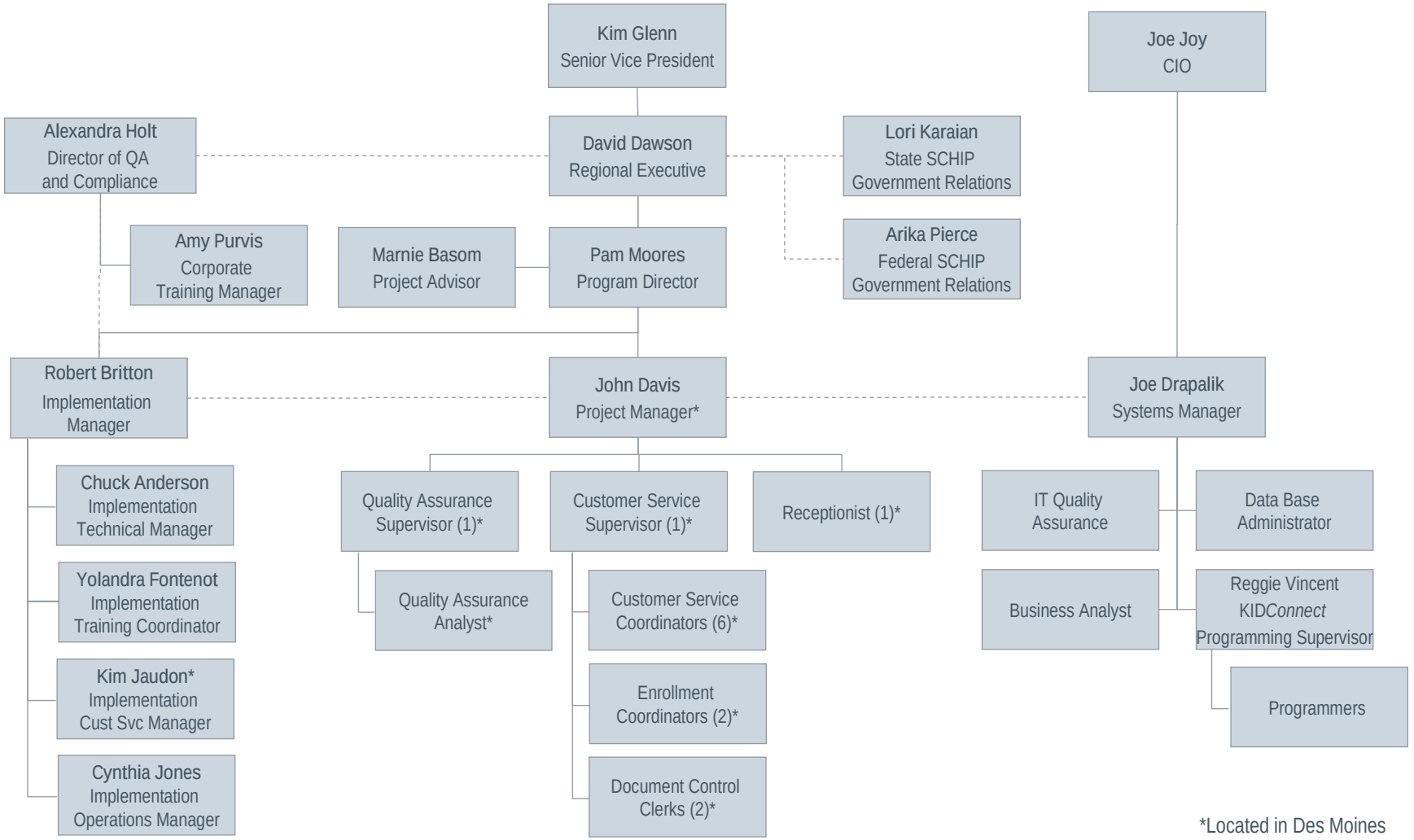


Exhibit 4.2.8-B: HMS Inc.'s Proposed hawk-i Organization Chart



- Ensuring that performance measurements are met or exceeded
- Ensuring the accuracy of the procedures documentation and that the project team adheres to Department policies
- Working closely with the Department to meet or exceed the requirements of the contract and developing plans to accommodate current and future needs of the hawk-i program
- Reviewing and monitoring summary data to identify problems and ensure correct processing
- Developing best practices to improve team efficiencies and customer service delivery
- Identifying and addressing performance problems with the project team

Joseph Drapalik, Systems Manager

As Systems Manager for the ***hawk-i*** administrative services contract, Mr. Drapalik will be responsible for the maintenance and modification of the **KID***Connect* suite of applications. Major duties of his position include:

- Serving as the primary technical contact for the Department
- Providing leadership and direction for the systems development team supporting the **KID***Connect* suite of applications
- Ensuring that software applications and system development meet the Department's requirements
- Troubleshooting hardware and software issues
- Ensuring a nightly application backup
- Working with the Department to ensure **KID***Connect* meets the short-term and long-term needs of the ***hawk-i*** program

Robert Britton, Implementation Manager

To insure a successful implementation, HMS will use a transition team lead by Robert Britton, a former MAXIMUS employee who was the Senior Vice President responsible for SCHIP and Enrollment Broker Operations in California. He also served on teams sent into British Columbia and Texas to work on various problems associated with start-up and project operations. In British Columbia, he was responsible for mail room operations, reconfiguring facilities to accommodate the increase in staffing, call center resource planning tools, analysis of service level agreements (SLAs), and working with the shop stewards regarding working conditions. In Texas, he assisted with integrated eligibility issues and overall quality assurance programs. His knowledge of the MAXIMUS organization, operations, and systems will be invaluable to the Department during the transition from MAXIMUS to HMS. Mr. Britton has the background needed to ensure effective transition, including effective completion of transition tasks that precede and lead to effective program operations. HMS's approach to transition minimizes the risks associated with transition from MAXIMUS to HMS and ensures the state that HMS has correctly assessed the steps needed for a smooth and seamless transition.

Resumes for Ms. Moores, Mr. Davis, Mr. Drapalik, and Mr. Britton appear on the following pages.

Additional Project Staff

Supporting our key team members, HMS has an established corporate team and a well-defined local staffing plan for Iowa ***hawk-i***.

Skills and Experience of HMS's Corporate Leadership Team

Working in concert with Ms. Moores (Program Director), Mr. Davis (Project Manager), Mr. Drapalik (Systems Manager), and Mr. Britton (Implementation Manager), HMS's proposed corporate leadership team comprises individuals who have the skills and experience needed to start-up and maintain successful operations for the proposed ***hawk-i*** engagement. This team has the necessary experience and knowledge to operate an efficient and responsive project for the State of Iowa and program constituents.

Marnie Basom, Project Advisor

Name/Title:	Project Position:	Education:
Marnie Basom Regional Director	Project Advisor	▪ BS – 1991, Oregon State University ▪ MPH – 1994, Oregon State University
Project Role: Leverage SCHIP experience and serve in an advisory role through implementation and operations		
Professional Experience: ▪ 3 years' tenure at HMS, serving in account leadership roles and providing oversight for contracts with Medicaid state agencies focused on third party recovery ▪ Served as CHIP Coordinator and Medicaid Children's Program Manager for the state of Idaho for 3 years		Qualifications: ▪ Provided management and oversight for the Idaho CHIP, school based services, and EPSDT programs ▪ Duties included program planning, implementation, and evaluation, outreach and communication, training, drafting and applying policy and procedures, interpreting and applying federal and state legislation, collaborating with internal and external stake holders, responding to federal, legislative, and public requests

Kim Jaudon, Implementation of Customer Service

Name/Title:	Project Position:	Education:
Kim Jaudon Account Services Director	Implementation of Customer Service	▪ BA – 1981, University of West Florida
Project Role: Leverage SCHIP experience and serve in an advisory role through implementation and operations		
Professional Experience: ▪ Former Vice President of Customer Service for Policy Studies, Inc., ▪ more than 25 years of experience spanning all operational aspects of human services programs, including medical support operations, customer service operations, case management, and large system implementations		Qualifications: ▪ Implemented Iowa's first statewide child support call center and cutting-edge statewide employer customer service unit (Employers Partnering in Child Support (EPICS)). ▪ Supervised more than 100 staff members in five offices across Iowa while completing all contract goals 18 months ahead of schedule (5-year term). ▪ Performed policy development, training development and delivery, process improvement, program improvement, and customer service practices

Cynthia Jones, Implementation Operations Manager

Name/Title:	Project Position:	Education:
Cynthia Jones Director, Enrollment Services	Implementation Operations Manager	▪ BA – 1993, Northwestern University ▪ MS – 1998, Rush University
Project Role: Assist with system development and operational processes during project implementation		
Professional Experience: ▪ 5 years' tenure at HMS, serving in program director and account management roles for Iowa, Michigan, Indiana, and Illinois, providing oversight for contracts with Medicaid state agencies focused on third party recovery ▪ Led the implementation the Iowa SCHIP COB*Match* contract in 2007 and the implantation of the Iowa Medicaid Revenue Collections contract in 2004.		Qualifications: ▪ Provided management and oversight for the Idaho CHIP, school based services, and EPSDT programs ▪ Duties included program planning, implementation, and evaluation, outreach and communication, training, drafting and applying policy and procedures, interpreting and applying federal and state legislation, collaborating with internal and external stake holders, responding to federal, legislative, and public requests

Reginald Vincent, KID*Connect* Programming Supervisor

Name/Title:	Project Position:	Education:
Reginald Vincent Senior Systems Engineer	Systems Development Supervisor	▪ Bachelor of Engineering – 1997, Stevens Institute of Technology
Project Role: Provides senior development leadership to Mr. Drapalik and HMS's ***hawk-i*** project management team		
Professional Experience: ▪ 4 years with HMS as Senior Systems Engineer ▪ 2 years as Senior Software Engineer with Newview Corporation, Inc. ▪ 1 year as Lead Developer with Electronic Raw Material Acquisition ▪ 1 year as Programmer/Analyst with E-SteelExchange		Qualifications: ▪ Designed and developed key components to HMS's e-Center framework, allowing for rapid deployment of case management system to clients ▪ Migrated several contracts to case management system using industry-proven tools ▪ Integrated imaging capabilities into case management system

Charles Anderson, Vice President of Corporate Development

Name/Title:	Project Position:	Education:
Charles Anderson Vice President of Corporate Development	Implementation Technical Mgr Application Architect: KID*Connect* suite of applications	▪ BS – 1975, City College of New York ▪ MBA – 1992, Golden Gate University
Project Role: Oversees development and implementation of KID*Connect* application		
Professional Experience ▪ 12 years with the Hearst Corporation in various operations management roles ▪ 7 years' experience in consulting/executive oversight roles with various companies in the pharmaceutical benefit industry ▪ 4 years with HMS; currently responsible for executive oversight of pharmacy and commercial insurance overpayment services		Qualifications ▪ 23 years' experience in pharmacy information technology and operations ▪ Expertise in product development and business strategy ▪ In-depth knowledge of pharmacy billing procedures and identification of abusive billing practices

Kim Glenn, Senior Vice President of Government Services

Name/Title:	Project Position:	Education:
Kimberly Glenn, HIA Senior Vice President of Government Services	Executive Project Advisor	BS – 1989, Colgate University

Project Role: Works with Mr. Dawson and Ms. Moores to ensure that appropriate HMS resources are available and committed at every stage of the project; fully accountable for the team's success and provides a senior-level contact for quick resolution of any issues or concerns

Professional Experience:	Qualifications:
▪ 18 years of experience directly managing third-party identification and recovery projects for 20 Medicaid Agencies, two State Health Plans, and several Medicaid Managed Care Plans ▪ Provides executive oversight of HMS's services on behalf of SCHIP programs in Iowa and Pennsylvania	▪ Directs client project implementations and ongoing operations in local offices ▪ Assists state clients in drafting TPL Action Plans ▪ Directs demonstration projects to identify Medicare beneficiaries with other insurance that is primary coverage

David Dawson, Midwest Regional Executive

Name/Title:	Project Position:	Education:
David Dawson Midwest Regional Executive	Managing Project Advisor	▪ BA – 1986, Carson-Newman College

Project Role: Works with Ms. Moores and Mr. Davis to oversee local Des Moines office operations and assure attainment of contract objectives

Professional Experience	Qualifications:
▪ 11 years with Perot Systems, Healthcare Division, focusing on delivery of healthcare IT solutions, including delivery of mailroom, claims processing, customer service, application development, and system and operational implementation services. ▪ 10 years with EDS, supporting state Medicaid operations in various capacities, including system programming, claims management, implementation support, and overseeing operations	▪ 21 years of experience in healthcare information systems for public healthcare programs and private healthcare organizations ▪ Oversees HMS account management and field offices in Mid-West Region

Joseph Joy, Senior Vice President and Chief Information Officer

Name/Title:	Project Position:	Education:
Joseph Joy Senior Vice President and Chief Information Officer	Executive Technical Advisor	▪ BS – 1984, Illinois State University ▪ Java Programming I, II and III – 2002, College of DuPage ▪ X-Technologies Developers Program – 2002, DePaul University

Project Role: Provides technical guidance and oversight to HMS's *hawk-i* project management team; provides guidance and direction to Systems Manager, Joseph Drapalik

Professional Experience:	Qualifications:
▪ 22 years of technology expertise, including programming and systems analysis ▪ 4 years as senior level information systems officer at HMS ▪ Coordinates, facilitates, and consults with all senior management staff on information systems, application development and support and IT project initiatives	▪ Manages operations for HMS's data centers ▪ Manages multiple information systems and projects, including legacy mainframe applications, data warehouse/datamarts, document imaging and workflow, web-deployed applications and other office automation systems ▪ Directs information systems staff

William Lucia, President and Chief Operating Officer

Name/Title: William Lucia, FLMI President and COO	Project Position: Contract Advisor	Education: ▪ Degree Course – 1986, San Francisco City College ▪ Finance for Senior Executives – 2003, Harvard Business School
Project Role: Ensures corporate-wide commitment to the success of ***hawk-i*** operations		
Professional Experience: ▪ 24 years of experience in healthcare reimbursement, information systems, and large-scale insurance administration ▪ 13 years of experience managing revenue recovery projects for healthcare providers and payors ▪ Advises HMS clients on business process re-engineering and assists in defining protocols for improved recovery ▪ Directed the implementation of HMS engagements in Colorado, Florida, and Maryland		Qualifications: ▪ President since 2003, he oversees all aspects of HMS's operations, including marketing, sales, and product development ▪ Instrumental in expanding HMS's products and launching our federal revenue maximization and strategic sourcing offerings ▪ Oversaw the successful merger of HMS with Public Consulting Group's Benefit Solutions Practice Area in 2006

Alexandra Holt, Director of Quality Assurance and Compliance

Name/Title: Alexandra Holt Director of Quality Assurance and Compliance	Project Position: QA/Compliance Manager	Education: ▪ BA – 1973, Oberlin College ▪ MA – 1975, Cornell University
Project Role: Monitor and ensure regulatory and contract compliance		
Professional Experience: ▪ 20 years' tenure at HMS in multiple capacities related to QA, Corporate Compliance, training, and contract operations		Qualifications: ▪ Develops and implements QA controls within HMS operational units ▪ Oversees employee training, development of standard operating and QA procedures, and technical documentation of processes ▪ Instrumental in creating HMS's human resources, technical documentation, and training infrastructures

Local Staffing Plan

Considering all project needs, HMS has developed a preliminary local staffing plan that calls for:

- 1 Program Director
- 1 Project Manager
- 1 Systems Manager
- 1 Administrative Assistant
- 1 Customer Service Supervisor
- 1 Quality Assurance Supervisor
- 1 Quality Assurance Analyst
- 6 Customer Service Coordinators
- 2 Enrollment Coordinators
- 2 Document Control Clerks

Hiring Plan

Program Director Pam Moores and Project Manager John Davis, supported by HMS's Human Resources staff, will oversee recruiting, hiring, and training local Iowa staff. Following notice of contract award, our first line of recruitment, with the Department's approval, will be to approach current MAXIMUS local staff and assess their qualifications and determine their interest in continuing to perform their duties when HMS assumes responsibility for the local office. The advantages to hiring current local staff are numerous: for the Department, the primary advantage is assured operational continuity into the new contract term. Existing staff already understand the ***hawk-i*** program and how their positions support program constituents; their learning curve will be shorter in that they need only learn HMS systems and protocols. To assure that MAXIMUS contract operations run smoothly during the implementation period (and that current MAXIMUS staff are not distracted during working hours by preparations for an impending move to HMS), we would conduct orientation and training sessions for these personnel at night and during the weekend.

In addition to recruiting existing MAXIMUS staff, HMS will recruit qualified staff consistent with the position descriptions developed. HMS has significant experience recruiting exceptional staff, even in tight job markets. We plan to obtain applicants from the following sources:

- **Advertising.** We will advertise locally in leading newspapers, such as the *Des Moines Register* and dmregister.gannettonline.com and on-line at monster.com.
- **Local job training offices.** We will post positions with Iowa Workforce Development and any other appropriate community agencies.
- **Local community college, colleges and universities, and trade schools.** We will visit local post-secondary institutions such as Des Moines Area Community College (DMACC), Iowa State University, and AIB Institute to introduce ourselves to the placement staff. We will also participate in job fairs to build a pool of applicants.

At the Iowa Medicaid Enterprise, HMS was tasked with hiring 16 positions to fulfill the duties of the contract. We were successful in hiring this staff through the processes documented above and through developing long-lasting relationships with local temporary agencies, which we draw upon from time to time to temporarily replace staff or augment our current staff to address high-volume workloads.

Staff Roles and Responsibilities

Below, we provide an overview of the roles and major duties for all local staff. **Exhibit 4.2.8-C** provides a comprehensive overview of each position and job description.

Exhibit 4.2.8-C: HMS Has a Detailed Plan for Hiring and Retaining Local Staff to Perform Local Office Operations

Position	Job Description
Customer Service Supervisor	In coordination with the Project Manager, the Customer Service Supervisor is responsible for providing leadership, day-to-day program oversight, and operations management. This person's focus is on motivation, problem-solving, and teamwork-enhancing behaviors to create a productive work environment for all staff. The Customer Service Supervisor will leverage project and staff resources effectively to ensure that office performance goals are met or exceeded and a high level of customer service is delivered to all customers. The Customer Service Supervisor's major duties include: ▪ Developing methods for processing, tracking, and evaluating customer requests and ***hawk-i*** applications to analyze efficiency and continuously improve customer service delivery ▪ Verifying existing customer demand patterns and developing plans to accommodate current and future demands ▪ Reviewing and monitoring case data to identify problems with case data and ensure correct case processing ▪ Developing best practices to improve team efficiencies and customer service delivery ▪ Identifying and addressing performance problems in project teams and individual staff
Customer Service Coordinator	The Customer Service Coordinator will be the primary contact with ***hawk-i*** enrollees and applicants. In addition, this team member will be cross-trained to perform all application processing and enrollment duties. Other major duties of this position include: ▪ Receiving information on new or existing cases from ***hawk-i*** enrollees and applicants ▪ Verifying existing case data and updating case data based on information received, and creating an explanatory case note ▪ Researching customer issues ▪ Using all available resources to resolve customer concerns ▪ Providing support to the Enrollment Coordination team during non-peak time call hours
Enrollment Coordinator	The Enrollment Coordinator is primarily responsible for screening applications for ***hawk-i*** and determining initial and ongoing eligibility. Major duties of this position include: ▪ Establishing case files in KID*Connect* and processing applications in accordance with state requirements and policies and procedures. ▪ Processes applications through evaluation of supporting information submitted by the applicant and through verification of information submitted through other source verification data bases and applying rules for determining eligibility. ▪ Investigate inconsistencies for possible fraud and for ensuring each applicants supporting documentation supports each eligibility determination. ▪ Meeting production and accuracy standards adopted by the organization. ▪ Stay current with policies and procedures, rules and regulations associated with eligibility of applicants and enrollees in the ***hawk-i*** program ▪ Providing support to the Customer Service Coordinators by answering calls from applicants or enrollees during peak call times

Position	Job Description
Document Control Clerk	The Document Control Clerk is responsible mail room operations including: ▪ Opening, sorting, date stamping, and batching mail received ▪ Imaging all incoming mail ▪ Indexing key fields for all scanned documents that will be used to locate documents within KID*Connect*, including timely and accurate indexing of applications to cases enabling the Eligibility Coordinators to perform their jobs in a timely and efficient manner
Quality Assurance Supervisor	The Quality Assurance Supervisor is responsible for coordinating all quality assurance activities for the account. Major duties include: ▪ Coordinating all activities with our corporate QA team to ensure that best practices are implemented and being followed ▪ Providing leadership to the QA team ▪ Working with the account leadership team to identify training issues and implement plans for additional training ▪ Completing audit activities within specified timeframes ▪ Identifying and reporting audit/error trends and recommending corrective action plans to the departments ▪ Serving as the main contact with the Department regarding QA activities, root cause analysis, and implementation of corrective action plans
Quality Assurance Analyst	The Quality Assurance Analyst conducts audits on project activities. Major duties include: ▪ Completing audit activities within specified timeframes ▪ Working closely with supervisors to identify training issues ▪ Identifying and reporting audit/error trends and recommending corrective action plans to the departments
Administrative Assistant	The Administrative Assistance will provide secretarial and administrative support, including: ▪ Receptionist/greeter for ***hawk-i*** applicants who visit the HMS Des Moines office ▪ Photocopying, faxing, maintaining files, sorting and routing mail, answering phone ▪ Maintaining managers' calendars, scheduling appointments, making travel arrangements ▪ Screening phone calls, providing information to callers, obtaining information from callers, and routing calls to appropriate staff ▪ Drafting and finalizing correspondence ▪ Preparing reports, including budget and statistical records of performance data ▪ Overseeing facility maintenance issues, including the ordering of office supplies ▪ Coordinating staff meetings, including arranging logistics, sending meeting notices, preparing agendas, issuing agendas and meeting materials, preparing meeting summaries, and tracking assignments resulting from meetings

4.2.8.3 Subcontractors

Provide the name and qualifications of any subcontractor who will be involved with this project. Describe the work and estimate the percent of total work the subcontractor will be performing.

With all of the resources necessary to successfully implement and maintain the proposed ***hawk-i*** TPA engagement all ready in-house, HMS will not subcontract work to outside parties.

4.2.8.4 Other Contracts

Describe other contracts and projects currently undertaken by the bidder.

Throughout our history, HMS has provided value-added cost recovery and cost containment services to government healthcare programs. Within the last twelve years, we have also performed services related to enrollment and disenrollment in government programs, including Health Insurance Premium Payment (HIPP) operations and managed care to fee-for-service case management services. This history of providing services to the public sector has enabled government-sponsored healthcare entities in 40 states to contain costs, expand service delivery, recover funds, and improve technology. Our experienced human, technological and operations resources will provide the foundation to deliver a seamless implementation for this project for the Iowa ***hawk-i*** program.

HMS's Successful Delivery

HMS currently provides customer service, case management, information technology, provider relations, and consulting services to each of our clients throughout the nation.

HMS currently provides a range of services for the 37 state agencies listed in **Exhibit 4.2.8-D**. We provide additional information on these contracts in **Section 4.2.7: Experience**.

Exhibit 4.2.8-D: HMS's Current State Agency Client Experience

HMS Client	Project				
	SCHIP Support (eligibility verification, third party recovery)	HIPP	Eligibility Verifications	Third Party Liability Identification and Recovery	Revenue Maximization
AL Medicaid Agency			✓	✓	
AK Dept. of Health and Social Services	✓	✓	✓	✓	
AZ Health Care Cost Containment System	✓		✓	✓	
AR Dept. of Human Services	✓		✓	✓	
CA Dept. of Health Care Services				✓	
CO Dept. of Health Care Policy and Financing			✓	✓	✓
CT Dept. of Social Services	✓			✓	✓
DE Dept. of Health and Social Services	✓			✓	

Exhibit 4.2.8-D: HMS's Current State Agency Client Experience

HMS Client	Project				
	SCHIP Support (eligibility verification, third party recovery)	HIPP	Eligibility Verifications	Third Party Liability Identification and Recovery	Revenue Maximization
DC Medical Assistance Administration				✓	
FL Agency for Health Care Administration	✓	✓	✓	✓	✓
GA Dept. of Community Health	✓	✓	✓	✓	
ID Dept. of Health and Welfare	✓		✓	✓	
IL Dept. of Public Aid			✓	✓	
IN Family and Social Services Administration	✓			✓	✓
IA Dept. of Human Services	✓		✓	✓	
KS Health Policy Authority	✓				
KY Dept. for Medicaid Services	✓	✓	✓	✓	
LA Dept. of Health and Hospitals				✓	
ME Dept. of Human Services				✓	
MD Dept. of Health and Mental Hygiene	✓		✓	✓	✓
(MA) MassHealth	✓	✓	✓	✓	✓
MI Dept. of Community Health			✓	✓	
NV Dept. of Human Resources, Division of Health Care Financing and Policy	✓		✓	✓	
NJ Dept. of Human Services	✓		✓	✓	✓
NM Human Services Dept.				✓	
NY Dept. of Health			✓	✓	
NC Dept. of Health and Human Services	✓		✓	✓	
ND Dept. of Human Services				✓	
OH Dept. of Job and Family Services				✓	
OK Health Care Authority	✓				✓
PA Dept. of Public Welfare	✓		✓	✓	✓
RI Dept. of Human Services				✓	
SC Dept of Health and Human Services	✓	✓	✓	✓	
SD Dept. of Social Services			✓	✓	
(TN) TennCare			✓	✓	
TX Health and Human Services Commission	✓		✓	✓	
VA Dept. of Medical Assistance Services	✓			✓	✓
WV Dept. of Health and Human Resources	✓	✓	✓	✓	

4.2.9 Financial Information

The bidder must provide the following financial information:

4.2.9.1 Audited Financial Statements

Submit audited financial statements (annual reports) for the last three (3) years.

HMS's financial results are reported together with those of our parent company, HMS Holdings Corp. ("Holdings"). HMS has provided our audited financial statements for Fiscal Years 2004, 2005, and 2006 as **Attachment 2 (Volume 2)** in this Proposal. These financial statements include:

- Balance sheets
- Income statement
- Statement of operations
- Statements of cash flows
- Notes to financial statements
- Auditor's reports

HMS's financial data are available on an ongoing basis. We are a publicly traded corporation and therefore subject to Securities and Exchange Commission (SEC) reporting requirements, which are more stringent than reporting requirements for privately held companies. In addition, HMS's current and historical financial reports are readily accessible through public channels, including SEC reporting sources and the Web sites of both HMS, Inc. and HMS Holdings Corp.

HMS's Chief Financial Officer, Walter Hosp, is available to answer any questions regarding the financial statements we have included; his telephone number is 212.857.5940.

4.2.9.2 Financial References

Provide a minimum of three (3) financial references.

HMS's ability to perform successful cost containment and recovery projects for 47 Medicaid agencies, 29 managed care organizations (including eight of the top nine Medicaid managed care organizations), 15 child support agencies, 120 Veterans Health Administration facilities, and the Centers for Medicare and Medicaid Services demonstrates that we have adequate financial resources to support multiple, ongoing engagements. Underscoring the more than sufficient nature of our financial resources is the fact that HMS performs these projects as the primary (and often sole) contracting entity. Since initiating our service relationship with Department in 1989, we have exhibited the financial capability required to meet and support all contract requirements.

Analysis of HMS Financial Statements

Financial analysts often look to the following items when assessing the financial health of a company:

- **Cash in the bank.** HMS had more than $6.7 million of cash and cash equivalents as of September 30, 2007.
- **Cash flow.** HMS is profitable (net income of $10.9 million for the nine months ended September 30, 2007) and generates positive cash flow (cash provided by operations was $13.8 million for the nine months ended September 30, 2007). HMS's positive cash flow has also been very consistent.

Furthermore, HMS has available a $25 million Revolving Credit Facility with a group of four banks under which we can borrow at any time. As of the date of this proposal (February 8, 2008), HMS had no borrowings outstanding under this Facility.

Finally, in addition to the items above, the financial community assesses a company's current ratio (current assets divided by current liabilities) as a key indicator of its financial health and stability. HMS has an overall strong financial profile. Debt-to-Equity ratio is less than 20% and the ratio of Assets/Liabilities is almost 4:1. These ratios demonstrate a conservative financial position.

HMS currently receives payment for serving 53 state agency clients. With more than $6.7 million in cash and cash equivalents, HMS already possesses and can maintain sufficient tangible net worth to provide for unexpected fluctuations or trends in project costs, or any other cost overruns, or to withstand payment delays. In addition, HMS has not filed any bankruptcy or insolvency proceedings, whether voluntary or involuntary, within the last 10 years.

HMS Credit References

As a public company (NASDQ:HMSY), HMS's financial information is registered and available at the Securities and Exchange Commission. We provide the following credit reference both for general purposes and also to address HMS's capability to fund projects to completion:

JPMorgan Chase Bank
1166 Avenue of the Americas, 15th Floor
New York, NY 10036

Contacts:
Charles L. Swarns, Jr., Telephone: 212.899.1435
Vickie Pizarro, Telephone: 212.899.2754

KPMG LLP
150 John F. Kennedy Parkway
Short Hills, NJ 07078

Contact:
Mark A. Thomas, Telephone: 973.912.4842

FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

September 17, 2007

Ms. Anna Ruggle, Issuing Officer
Iowa Department of Human Services
Division of Financial, Health and Work Supports
1305 E. Walnut, 5th Floor
Des Moines, Iowa 50319-0114

Dear Ms. Ruggle:

Health Management Systems, Inc. (HMS) performs accounting-based payment processing services necessary to administer the Florida Agency for Health Care Administration's Medicaid Opt Out Program. Opt Out is a new Medicaid Reform program whereby Medicaid beneficiaries are provided the opportunity to "opt out" of Medicaid into employer sponsored health insurance plans. The focus of our efforts is to enroll beneficiaries in the Opt Out Program when they qualify and manage the premium reimbursement efforts on behalf of the Agency. HMS performs the following activities:

- Manage inquiries from beneficiaries interested in the Opt Out Program;
- Assist beneficiaries with determining whether or not they qualify for the program;
- Enroll beneficiaries who qualify for the program;
- Receive and process proof of employment and proof of enrollment in an employer sponsored health insurance plan for each program participant on a schedule set by the participant;
- Generate and issue premium reimbursement to program participants;
- Maintain program participant information in a database system;
- Follow up with program participants when no proof of employment is received.

HMS's efforts on behalf of the Agency have resulted in the enrollment of several participants in the Opt Out program. HMS continually demonstrates a comprehensive understanding of state-specific issues, and applies innovation and best practices in order to fulfill contract requirements.

I look forward to answering any questions you may have regarding HMS's successful efforts on behalf of the Florida Agency for Health Care Administration. You may contact me by phone at (850) 487-0925 or by e-mail at barrettj@ahca.myflorida.com.

Sincerely,

Jennifer W. Barrett

Jennifer W. Barrett, AHCA Administrator
Third Party Liability
Bureau of Program Analysis

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

September 11, 2007

Ms. Anna Ruggle, Issuing Officer
Iowa Department of Human Services
Division of Financial, Health and Work Supports
1305 E. Walnut, 5th Floor
Des Moines, Iowa 50319-0114

Dear Ms. Ruggle:

Health Management Systems, Inc. (HMS) performs a comprehensive Third Party Liability and Medical Support Enforcement enhancement project for the West Virginia Department of Health and Human Resources. The focus of our efforts is to identify new third-party insurance policies and recover Medicaid funds from previously paid claims. HMS performs the following activities:

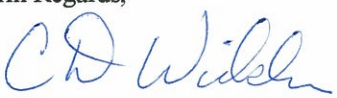
- Administration of the Health Insurance Premium Payment (HIPP), casualty and estate recovery programs on behalf of the State through the use of internally created Web-based applications;
- Data matching with commercial, Medicare, and TRICARE files to identify active coverage;
- Verifying TPL leads from local welfare offices and data matches;
- Providing accretions, updates, and terms as part of maintaining the third-party resource file;
- Generating and monitoring commercial billings for Drug, CMS 1500, and UB-92 to all major carriers including Medicare Part B and TRICARE;
- Generating and monitoring provider recoveries on UB-92 claims to providers with all major carriers including commercial insurers and Medicare Part A;
- Conducting credit balance reviews of hospital and long term care providers;
- Developing electronic claim submissions according to NSF 2.0 and 5.0;
- Implementing electronic claims submissions for TRICARE and Medicare Part B;
- Developing and tracking casualty leads using data matches with the Division of Motor Vehicles and the Bureau of Workers' Compensation;
- Developing and tracking leads using vital statistics file for estates;
- Conducting enforcement efforts for IV-D cases where an active medical support order exists and children are not currently enrolled in private health insurance;
- Matching commercial insurance eligibility records with West Virginia case files to identify health coverage for IV-D Medicaid and Non-Medicaid children;
- Matching non-custodial parent and Medicaid eligibility files with the statewide wage reporting file and employer new hire file to identify new insurance and medical support enforcement opportunities; and

- Implementing a Medicare Part A reprising project with providers that documents allowable pass-through costs with ongoing benefits provided to the State through annual updates of provider information.

HMS's efforts on behalf of the West Virginia Medicaid program have resulted in more than $60 million in recoveries. HMS continually demonstrates a comprehensive understanding of our state-specific issues, and applies innovation and best practices in order to fulfill contract requirements.

I look forward to answering any questions you may have regarding HMS's successful efforts on behalf of the West Virginia Department of Health and Human Resources.

Warm Regards,



Ms. Charlotte Wickline,
HHR Associate
State of West Virginia
Department of Health and Human Resources
350 Capitol Street, Rm. 251
Charleston, WV 25302-3709
Telephone: 304.558.1761
E-mail: charlottewickline@wvdhhr.org

Robert Britton

TRANSITION LEAD

BUSINESS DEVELOPMENT & PROJECT OPERATIONS SPECIALIST

Medicaid Enrollment • SCHIP • Business Development • Project Management • Government Relations

Medicaid and TPL Recovery • Provider Relations • Process Development and Implementation

Technical Support • Research & Product Development • Client Satisfaction • Business Solutions

Strategic Planning • Contract Compliance • P&L Management • Strategic Partnerships

Quality Assurance • Proposal Development

Current Practice

HEALTH MANAGEMENT SYSTEMS, INC., 2007 – present
Transition Lead, 2007 – present

Career History

MAXIMUS, 1997 – 2007

Division President, Western Region

Senior Vice President Business Excellence, Health and Human Services Segment

Senior Vice President and Chief Operations Officer, Western Region

Project Director and Project Manager

Senior Operating Executive with full strategic planning P&L management responsibility for the $95 million Division of a $650 million Corporation.

Maintained complete decision making authority within the company's authority matrix for Health Products and Services in the Western United States.

Managed up to eight direct reports and 1,250 indirect reports.

Participated on turn-around teams for troubled projects in California, British Columbia, Texas, and Tennessee.

- Launched aggressive reengineering of operations and guided projects in the Western Region to the position of leading financial performer among all the Health Service projects in the company.
- Delivered unprecedented results by erasing a $1.2 million forecast loss on earnings of $36 million in one project.
- Exceeded sales forecast each year for six consecutive years.
- Improved overall productivity of forms processing by over 600% in seven years.
- Negotiated a long-term strategic alliance with a fulfillment vendor responsible for mailing materials to beneficiaries in California's Medicaid program.
- Led efforts to develop a Quality Assurance program for the first privatized integrated eligibility project in the nation.
- Led efforts to develop a case management system for the Drug and Alcohol Diversion program for licensed health Care Professionals in California.

In 1996, directed successful merger of PMR and Landmark; after establishment of the new management team, exited new company to start another consultancy (Coordinated Care Strategies).

Developed a full managed care network for a Fortune 500 corporation in Colorado until being offered key position in a publicly traded company.

PREFERRED MANAGEMENT RESOURCES

President and Chief Executive Officer, 1986 – 1996
Started and subsequently grew a management services and consulting company: PMR provided a full range of services for managing multi-specialty providers contracting with managed care companies to provide health care services.

Responsible for all facets of day-to-day business operations ranging from planning and business development through financial management and client relations.

Developed a strategic alliance with a Company now named Landmark Healthcare and established PMR as the dedicated management arm of this organization.

As President, responsible for strategic planning, business development, provider agreements, and administration of the company and its six subsidiaries in five states.

- Generated rapid growth of PMR, setting company on consistent 100% annual growth rate.
- Introduced business development programs which doubled Landmark's gross revenue each for five years, taking sales to more than $15 million.
- Increased number of persons covered under Landmark programs from 10,000 to more than 1.3 million.
- Increased participating providers in Landmark from approximately 20 to more than 2,500 in five states.
- Obtained and negotiated managed care contracts for Landmark with 14 major HMO's in five states, seven preferred provider organizations, and two Workers Compensation carriers.
- Prepared initial documents for planned filing of Landmark's specialty HMO license in California.
- Prepared Landmark's business plan to expand HMO license and related products to other states.
- Used plan to raise $10 million from private investors to take Landmark public; also, led evaluation of possible acquisition targets.

LOS ANGELES COUNTRY FOUNDATION FOR MEDICAL CARE, INC.

DOCTORS INDEPENDENT PRACTICE ASSOCIATION, INC.

Executive Director, 1983 – 1986

Selected in 1983 by the Los Angeles County Medical Association, the largest County Medical Society in the United States, to start-up Los Angeles Foundation for Medical Care, Inc and Doctors Independent Practice Association, Inc.

Key accomplishments included development of:

- 60 hospital contracts with preferred rates for services.
- 2,600 physician contracts geographically dispersed throughout Los Angeles County.
- 250 allied provider contracts.
- An exclusive agreement with CIGNA Private Practice Plan including business plans with a $50 million budget largely funded by CIGNA, then a $400 million HMO.
- Preparation and development of Medical Review Guidelines used to operate participating Health Care Programs in Los Angeles County.
- Installation and operation of a new third-party medical claims processing system.

Partial Client List

District of Columbia Medical Assistance Administration

Indiana Family and Social Services Administration

Iowa Department of Human Services

Louisiana Department of Health and Hospitals

Missouri Department of Social Services

New York Department of Health

Education

California State University, Sacramento
B.A., Communication Studies, 1972

Professional Memberships

Project Management Institute (PMI)

American Society for Quality (ASQ)

Joe Drapalik

DIRECTOR, APPLICATIONS DEVELOPMENT

health management systems

EXPERIENCED PROGRAMMING PROFESSIONAL

Software Design • Information Systems Development • Analyst Team Manager

Current Practice

Director, Applications Development, 2006 – present

- Direct and coordinate all activities within the department including design, programming, and testing of all eCenter applications.
- Responsible for providing effective computer service to both internal and external users.
- Assist in determining business requirements for various application changes through personal experience and interviewing end users.
- Make determination as to project feasibility through knowledge of system capacity.
- Control and assign work to programmers, business analysts, and quality assurance analysts.
- Recommend, document, and implement operating policies and procedures
- Analyze department production and redesign internal workflow where appropriate.
- Forecast budgetary needs and periodically perform budget analysis to ensure effective spending.
- Provide general management of all employees and consultants.
- Ensure successful and timely implementation and roll-outs of all eCenter applications including:
  - Provider Portal Self-Audit
  - Provider Portal Disallowance
  - National Eligibility Database
  - COBMatch
  - Socrates
  - Provider conversions (new/existing clients)
  - Phoenix
  - Cost avoidance (including referrals)

Systems Analyst II, 2004 – 2006

- Supervise all Business and Programmer Analysts in the Dallas Service Center responsible for eCenter, MDS, and Access Line.
- Manage large IT projects requiring advance planning and coordination with both internal and external clients.
- Perform both Business and Systems Analysis & Design on eCenter applications. Examples include:
  - COBManager - a solution that allows Medicaid to save millions of dollars by submitting claims over the same network pharmacies use to submit their own claims.
  - Provider Self-Audit - Allows providers to access claim data previously submitted to Medicaid, make corrections, and resubmit to the appropriate agency.
  - Consolidated Claim Data Base - A warehouse of claim data that can be shared by all eCenter applications.

Career History

DISCOVER FINANCIAL SERVICES
Senior Systems Analyst, 2001 – 2003

- Served as Release Manager for the Java-based business application Orion, responsible for planning, organizing, and implementing all aspects of monthly software releases.
- Designed and developed software solutions to incorporate new laws and regulations as they pertained to the financial industry specific to credit and debit cards.
- Researched and implemented new tools and hardware to support software development.
- Coordinated multiple software developers in development and maintenance of project plans.

HEALTH MANAGEMENT SYSTEMS, INC.
Project Team Manager, 1990 – 2001

- Planned and directed activities of multiple project teams in order to maximize customer satisfaction and meet team objectives.
- Responsible for managing resource allocation, development of budgets, as well as project plans and milestones.
- Responsible for management of several health insurance projects including:
    - Managed ITS upgrade for Blue Cross/Blue Shield of Western New York.
    - Developed Web-based eligibility system using a relational database for its data repository.
    - Rewrote TPL front-end system used for Medicaid payment recovery.

ILLINOIS AIR NATIONAL GUARD
Communications Officer, 1984 – 2004

As a Major in the 217th E&I Squadron, responsible for managing 70 military personnel whose primary function is the engineering, installation, and maintenance of communications and computer equipment. Other responsibilities included:

- Coordinate with other areas within the military to provide logistical requirements in support of team deployments both within and outside the United States.
- Managed 50 engineering and Installation personnel at Al Udeid AB, Qatar, for a period of seven months. Managed such communications projects as the Combined Air Operations Center (CAOC), Intelligence, Surveillance, and Reconnaissance Division (ISRD), Technical Control Facility (TCF), and the base fiber and copper communication infrastructure.

Education

Northern Illinois University, Dekalb, IL
BS, Applied Computer Science, 1989

Professional Certification

Project Management Institute
Project Management Professional Certification

John Davis

ACCOUNT MANAGER

health management systems

SCHIP REVENUE COLLECTION AND ELIGIBILITY SPECIALIST

SCHIP • Medicaid & TPL Recovery • Data Matching • Commercial Insurance Recovery

Technical Support • Medicaid & TPL Recovery • Revenue Maximization • Provider Relations

Client Satisfaction • Training • Claims Processing • Audits • Contract Compliance

Current Practice

Account Manager: Iowa Department of Human Services' Healthy and Well Kids in Iowa (*hawk-i*) Program for the Revenue Collection Division of the Iowa Medicaid Enterprise, 2006 – present

- Manage a staff of 16.
- Ensure that HMS meets or exceeds all requirements of our contract for the Iowa Medicaid program.
- Ensure that the third-party liability (TPL) verifications for the Iowa ***hawk-i*** program are completed in a timely manner.
- Ensure that HMS meets or exceeds all requirements of the ***hawk-i*** contract which includes returning of discovered TPL within three days to the ***hawk-i*** staff.
- Coordinate responding to provider appeals on behalf of Iowa.
- Attend legal pre-hearing and hearing conferences as it pertains to provider appeals on behalf of Iowa.
- Develop administrative guidelines and administration manuals for all recovery and processing efforts on behalf of Iowa.
- Train and develop staff on administrative and operational procedures.
- Perform all interviews and hiring of staff.
- Maintain processing and audit timeframes and accuracy.
- Establish production levels for staff.
- Coordinate all external and internal audits.
- Maintain weekly, bi-weekly, and monthly contact with the Iowa Medicaid staff to ensure operation satisfaction; includes conducting meetings and providing status reports.
- Complete all required weekly, monthly, quarterly, and annual reports as required by senior management and the Iowa contract.
- Prepare the annual operational budget for HMS's Des Moines, Iowa office.
- Liaise with vendors to ensure cooperation between all operational efforts so that the Iowa Medicaid program is successful (nine independent vendors work on behalf of the Medicaid program).

Career History

AMERICAN ADMINISTRATORS/SELECT BENEFIT ADMINISTRATORS (FORMERLY HOLMES MURPHY AND ASSOCIATES/SELECT BENEFIT ADMINISTRATORS)

General Manager, 1998 – 2006

- Managed the operations of the third-party administrator, including the claims, eligibility, and office support departments.
- Ensured quality service of healthcare benefits for customers.
- Developed administrative guidelines for staff.
- Conducted all interviews and hiring of staff.
- Established electronic claims processing system.
- Created a Web site for claim viewing by the customer.

- Created electronic billing and reporting processes for employer groups.
- Established automatic claims processing.
- Established a customer service module for recording of incoming telephone call detail.
- Maintained claim and audit timeframes and accuracy.
- Coordinated all external and internal audits.
- Facilitated meetings with employer groups and brokers.
- Created detailed monthly reporting by individual and group for claims processing, telephone totals, and audit accuracy.
- Maintained bi-weekly and monthly customer contact with employer groups for review of operation satisfaction.
- Coordinated all operational efforts for employer groups at renewal time.
- Created customer survey cards.

WELLMARK BLUE CROSS/BLUE SHIELD

Team Leader, 1995 – 1998

- Managed the operations of an open access, gatekeeper and capitated HMO product.
- Ensured quality service of healthcare benefits for our customers and timely reimbursement.
- Maintained claim and audit timeframes and accuracy.
- Established standards for quality and productivity, which included creating a "Quality Analyst" position.
- Initiated and wrote a worker's compensation training manual.
- Developed administrative guidelines for staff.
- Conducted all interviews and hiring of staff.
- Oversaw the posting of checks and the authorization of vendor payments for health claims.

CIGNA HEALTH INSURANCE

Team Leader, 1982 – 1990

- Processed medical and dental claims for fully and self -insured accounts.
- Responded to incoming customer service calls regarding health benefits and claims payments.
- Supervised a staff of claims processors in the administration of 17 group plans.
- Ensured that claims were processed accurately and in a timely manner.
- Interacted with health care providers and clients: answered questions regarding claims, plan coverage and assisted in resolving discrepancies.

Partial Client List

Iowa Department of Health Services: *hawk-i*

Education

University of Northern Iowa
B.A., Economics

Pamela Moores

PROGRAM DIRECTOR

health management systems

HEALTHCARE / MANAGED CARE PROJECT MANAGEMENT SPECIALIST

Commercial Insurance Recovery • Business & Contract Development • Operations Management

Medicaid and TPL Recovery • Data Matching • TRICARE/Champus • Carrier Relations • Revenue Maximization • Quality Assurance • Contract Compliance • Clinical Nursing • Contract Negotiation

Business Analysis • Managed Care • Program Development • Project Management • Strategic Planning

Current Practice

Program Director, 2008 – present

- Works closely with clients to develop a complete understanding of their business and operations; facilitate accurate identification of specific recovery projects that will best meet clients' fiscal and programmatic needs.
- Serves as the principal technical and contract support contact between HMS technical staff and the client to ensure client satisfaction, including the timely management of project deliverables, release of billing cycles, performing analyses, maintaining compliance with state and federal agency regulations, managing client relationships, and ensuring client satisfaction.
- Develops procedures for program implementation and improvement and provide quality control review.
- Develops HMS revenue policies, projects, and procedures.
- Coordinates and communicate with numerous state and county agencies and outside vendors to ensure smooth and orderly program operations.
- Interprets statutes/regulations and submit suggestions for legislation and regulatory revisions to improve the program.

Career History

METRO COMMUNITY PROVIDER NETWORK (MPCN)
Director, Operations, 2006 – 2007

- Provided technical and operational support ensuring timely healthcare delivery to the underserved at 12 Denver Metro area clinics.
- Directed 10 clinic managers serving 38,000 patients, or 240,000 patient visits in all aspects of clinical operations.
- Addressed programmatic needs by creating nurse management teams to improve daily clinic operations.
- Lead grant proposal effort for the Colorado Trust to establish a specialty network at MCPN to refer the underserved population for healthcare.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, 1994 – 2006
Manager, IT Contracts & Monitoring/HIPAA Project Manager

- Assumed responsibility for the fiscal agent multi-million dollar contracts and operations in January 2004, and the development of an RFP for the reprocurement of fiscal agent services by December 2006.
- Supervised the Medicaid privacy officer and four technical/business analysts.
- Established a detailed project plan to coordinate the efforts of oversight contractors, the fiscal agent, and clearinghouse to achieve compliance with Federal HIPAA regulations.
- Managed the development and implementation of an interactive claims application Web portal for Medicaid claim submissions.
- Performed successful remediation of the Medicaid Management Information System (MMIS) and implementation of HIPAA rules to include the portability of insurance, privacy, transactions and code sets, and security.
- Designated privacy expert by the Centers for Medicare and Medicaid Services.

- Improved collaboration and communication with the Medicaid fiscal agent through meetings, education, and project partnering.
- Participated in Business Process Reengineering for a new eligibility system for Colorado, to include eligibility for human services programs, Medicaid, SCHIP, and Colorado-only healthcare programs.
- Assessed eligibility rules for each program to integrate data requirements.

Manager, Third Party Resources

- Supervised 10 staff members.
- Assured Medicaid is the payer of last resort on healthcare claims where a liable third-party was present.
- Assigned Tort and Casualty cases, Estate recovery, Child Support mandates, and coordination of benefits between Medicaid and third-party carriers to include commercial insurance, Medicare, and other federal coverage.
- Interpreted Medicare policy regulations to ensure correct claims payment for dually eligible clients.
- Secured and implemented a contract to expand TPL work in Colorado.
- Participated on a committee with the SCHIP staff (known as CHP+) sponsored by the Rose Foundation to assess the fiscal feasibility of buying health insurance through employer programs for CHP+ eligible children.
- Successfully defended challenges by estate attorneys regarding recovery rules through legislative committee testimony.
- Established a successful partnership with partners at the Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA).
- Increased Tort recoveries by 15% over three years.

Quality Assurance Administrator

- Supervised quality assurance controls to develop a monitoring system for Managed Care Organizations (MCOs) providing care for Medicaid clients.
- Developed Health Plan Employer Data and Information Set (HEDIS) measures for non-managed care claims through work with National Committee for Quality Assurance (NCQA).
- Developed quality indicators for SCHIP contracts.

Administrative Program Specialist

- Reviewed documentation to support submitted claims in response to fraudulent claims submission.
- Reviewed clients over-utilizing medical services by implementing cost containment efforts.
- Assessed paid claims during utilization review to monitor usage and determine appropriate use of medical services.
- Participated in review of provider billing practices—enhancing policy clarification and new medical services rules.

TRI-COUNTY HEALTH DEPARTMENT

Clinical Operations Coordinator - Women's Health Clinics, 1990 -1994

- Managed 25 staff across several clinics providing prenatal and family planning services.
- Responsibilities included: community relations, staff development, clinic schedules, budget accountability, and administration of contracts with the State health department and participating hospitals.
- Established two medical assistance sites to process Medicaid applications for prenatal services and determine presumptive eligibility for patients.

NURSING CAREER THAT SPANNED 15 YEARS, EMPLOYEED IN VARIOUS HEALTH CARE SETTINGS.

Partial Client List

Iowa Department of Human Services

Professional Affiliations

Trinity Hospice Board of Directors,
Member
***Colorado Nurses for Access to Healthcare for All* Group with Colorado Nurses Association,**
Participant
National Third Party Liability Technical Advisory Group,
Member
HEDIS Group and the National Committee on Quality Assurance,
Participant
Board of Colorado Community Health Network,
Chairman of the Operations Committee

Education

University of Colorado, Boulder, CO
Master of Public Administration (MPA), 1995

University of Wisconsin, Eau Claire, WI
B.S., Nursing, 1975

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

[X] **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2004

[ ] **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 0-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

New York (State or other jurisdiction of incorporation or organization)	**11-3656261** (I.R.S. Employer) Identification No.)
401 Park Avenue South, New York, New York (Address of principal executive offices)	**10016** (Zip Code)

(212) 725-7965
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act: None
Securities registered pursuant to Section 12(g) of the Act:
Common Stock
(Title of Class)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.
Yes [X] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [X]

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act).
Yes [X] No [ ]

Aggregate market value of voting stock held by non-affiliates as of June 30, 2004 was $110 million.

The approximate aggregate market value of the registrant's common stock, $0.01 par value, held by non-affiliates (based on the last reported sales price on the Nasdaq National Market) was $157.5 million at March 25, 2005.

The number of shares common stock, $0.01 par value, outstanding as of March 25, 2005 was 19,491,384.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the Annual Meeting of Shareholders to be filed pursuant to Regulation 14A on or before April 30, 2005 are incorporated in Part III of this report.

HMS HOLDINGS CORP. AND SUBSIDIARIES

ANNUAL REPORT ON FORM 10-K

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Special Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K contains "forward-looking" statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. For this purpose any statements contained herein that are not statements of historical fact may be deemed to be forward-looking statements. Without limiting the foregoing, the words "believes," "anticipates," "plans," "expects" and similar expressions are intended to identify forward-looking statements. These statements involve unknown risks, uncertainties and other factors, which may cause our actual results to differ materially, form those implied by the forward looking statements. Among the important factors that could cause actual results to differ materially from those indicated by such forward-looking statements include those risks identified in "Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Risk Factors" and other risks identified in this Form 10-K and presented elsewhere by management from time to time. Such forward-looking statements represent management's current expectations and are inherently uncertain. Investors are warned that actual results may differ from management's expectations.

PART I

Item 1. Business

Overview

HMS Holdings Corp. furnishes cost containment, revenue recovery, cost reporting and business office outsourcing services to healthcare providers and payors. We help our clients increase revenue, accelerate collections, and reduce operating and administrative costs. We operate two businesses through our wholly owned subsidiaries, Health Management Systems, Inc. (Health Management Systems) and Accordis Inc. (Accordis).

Health Management Systems works on behalf of government healthcare programs to contain costs by recovering expenditures that were the responsibility of a third party, or that were paid inappropriately. Health Management Systems' clients include state and county Medicaid programs, their managed care plans, child support enforcement agencies, state prescription drug programs and other public programs.

Accordis provides business office outsourcing services for hospitals, emergency medical transport agencies, and other healthcare providers. These business office services may include identifying third-party resources, submitting timely and accurate bills to third-party payors and patients, recovering and properly accounting for the amounts due, responding to customer service questions from patients, and securing the appropriate cost-based reimbursement from entitlement programs. Clients may outsource the entirety of their business office operations to us, or discrete components of the revenue cycle.

On March 7, 2005, we announced that we had commenced a strategic review of all of the alternatives available to us for increasing the return on the resources we employ in delivering services to providers through our Accordis subsidiary.

Subsequent to the issuance of our press release on March 7, 2005 announcing the results of operations for the fourth quarter and year ended December 31, 2004, the following items were recorded:

(1) We reclassified $22.5 million of municipal auction rate securities as short-term marketable securities, which were previously disclosed as cash and cash equivalents. This change in classification had no effect on the amounts of total current assets, total assets, net income or cash flow from operations.

(2) On March 8, 2005, we received $2.4 million in settlement of two accounts receivable from the District of Columbia and we also recognized contingent recovery fees and settlement expenses

approximating $0.7 million resulting from the settlement. Although this settlement was negotiated and received subsequent to December 31, 2004, we reflected it in the 2004 results of operations as the subsequent settlement of this litigation eliminated the need for a bad debt allowance against these accounts receivable at December 31, 2004. Accordingly, we adjusted accounts receivable at December 31, 2004 to $2.4 million, the amount of the settlement, and reduced bad debt expense by $1.7 million, which is included in direct project costs.

(3) We reclassified $2.0 million of deferred tax assets to current assets.

Healthcare Reform And Regulatory Matters

The healthcare reimbursement landscape continues to evolve. Federal, state, and local governments, as well as other third-party payors, continue their efforts to reduce the rate of growth in healthcare expenditures. Many of these policy initiatives have contributed to the complex and time-consuming nature of obtaining healthcare reimbursement for medical services.

Our clients are subject to comprehensive federal and state regulation, which affects hospital reimbursement. Medicaid and Medicare account for a significant portion of hospital revenue. Since adoption, the Medicaid and Medicare programs have undergone significant and frequent changes, and it is realistic to expect additional changes in the future. Our services are subject to regulations pertaining to billing for Medicaid and Medicare services, which primarily involve record keeping requirements and other provisions designed to prevent fraud. We believe that we operate in a manner consistent with such regulations, the enforcement of which is increasingly more stringent. Violations of such regulations could adversely affect our business, financial condition and results of operations.

The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency of the United States Department of Health and Human Services. CMS currently contracts with several intermediaries and fiscal agents to process regional claims for reimbursement. Although CMS has established the regulatory framework for Medicare claims administration, Medicare intermediaries have the authority to develop independent procedures for administering the claims reimbursement process. The Medicaid program is subject to regulation by CMS, but is administered by state governments. State governments provide for Medicaid claims reimbursement either through the establishment of state operated processing centers or through contractual arrangements with third-party fiscal agents who operate their own processing centers. The requirements and procedures for reimbursement implemented by Medicaid differ from state to state. Similar to the claims administration processes of Medicare and Medicaid, many national health insurance companies and self-insured employers adjudicate claims through local or regional offices. Consequently, because guidelines for the reimbursement of claims are generally established by third-party payors at local or regional levels, hospital and other provider reimbursement managers must remain current with the local procedures and requirements of third-party payors. Generally, we are required to maintain standards of confidentiality that are comparable to those of an agency administering the Medicare or Medicaid program when we use data obtained from such programs.

The Health Insurance Portability and Accountability Act of 1996 requires the Secretary of Health and Human Services to adopt national standards for certain types of electronic health information transactions and the data elements used in such transactions and to adopt standards to ensure the integrity and confidentiality of health information. All covered entities (providers, payors, and clearinghouses) will be mandated to implement administrative, physical, and technical safeguards to protect health data covered by HIPAA. The regulations are in the following stages of finalization and implementation:

Transaction and code set standards. The final regulation governing transaction and code set standards was published and was expected to become effective on October 16, 2002. However, on December 27, 2001 the Administrative Simplification Compliance Act (ASCA) was enacted providing for a one-year extension of the date for complying with the HIPAA standard transactions and code set requirements for any covered entity that submits to the Secretary of Health and Human Services a plan on how the entity will come into compliance with the requirements by October 16, 2003. We submitted such a plan to be in full compliance with the standard transaction and code set requirements by the October 16, 2003 deadline. As of October 16, 2003, however, a number of providers, payors and clearinghouses were still not ready to submit and/or

accept certain standard transactions. CMS, as well as a number of fiscal intermediaries and other payors, announced transition time periods during which legacy transaction and code set formats would still be accepted, albeit for a limited time only. As of December 31, 2004, a limited number of these transition periods, including the one announced by CMS, are still in effect. In these instances, as applicable, we continue to test with those trading partners operating under transition plans and expect to be fully compliant by the time the transition time periods expire.

Privacy Regulation. The privacy regulation was published as a final regulation and became effective on April 14, 2001, requiring all covered entities to be fully compliant by April 14, 2003. We believe we were in full compliance with the privacy regulation by the April 14, 2003 deadline and continue to be compliant.

Data Security. The data security regulation was published as a final regulation on February 20, 2003, with an effective date of April 21, 2003. Full compliance is required by April 21, 2005. We are working toward being fully compliant by that date and have every expectation of being so.

Any material restriction on the ability of healthcare providers and payors to obtain or disseminate health information could adversely affect our business, financial condition, and results of operations. With the release of the final HIPAA Privacy and Security rules, the "protection of individually identifiable healthcare information" becomes a key component of the way we and other covered entities perform our day-to-day business.

Principal Products And Services

Health Management Systems

Health Management Systems offers a variety of services that help government healthcare entitlement programs, most notably state Medicaid agencies, contain costs and recover revenue. To date, these revenue recoveries total more than $2.6 billion, after having passed the $2.0 billion milestone in October 2003.

Our services derive from the complexity of Medicaid and other healthcare entitlement programs, and the many rules that govern relationships among them. Established in 1965, Medicaid is administered by individual states, and is jointly funded by the federal and state governments. Because Medicaid is the "payor of last resort," the federal government imposed statutory obligations in the early 1980s requiring states to actively recover payments made on behalf of beneficiaries who have other forms of third-party health insurance.

In 1985, Health Management Systems began offering state Medicaid agencies services to identify third parties with prior liability for Medicaid claims. Using proprietary information management techniques, we have developed methodologies that generally include the following steps:

- Identification: We use proprietary software to match Medicaid and other program data files to insurance eligibility files obtained by us from third parties such as Medicare, Commercial Insurers, HMOs, Third Party Administrators, TRICARE, and others. This process identifies potential third-party eligibility.

- Validation: After identification of potential third-party liability, we validate insurance eligibility by verifying coverage for specific benefits. This process is performed by deploying automated electronic transactions and call center representatives.

- Recovery: When eligibility and coverage are in effect for a specific Medicaid member and related episode of care, we pursue recovery of the Medicaid payment from the liable third-party. Most often we recover from third-parties through direct billing of insurers or disallowance of overpayments to the provider of services. On occasion, we recover payments through negotiated settlements.

- Cost Avoidance: Upon verification of coverage or payment of claims by liable third-parties, we electronically submit this coverage data to our Medicaid clients. This data is used to avoid paying similar claims for the Medicaid member on a going forward basis.

These proprietary methodologies are the foundation for our suite of coordination of benefits (COB) services. In addition, we use a variety of auditing and information management techniques to help clients identify and recover other inappropriate payments – for example, duplicate payments, payments that are made on behalf of a deceased beneficiary, or payments that result from fraud and abuse.

Accordis

Accordis offers emergency medical transport providers, hospitals and other healthcare providers Business Office services and Reimbursement services.

Emergency Medical Transport Provider Services. We offer our clients a combination of technology, data processing capacity, and revenue cycle expertise to assist ambulance providers in improving cash flow and reducing the cost to bill and collect. Accordis applies its revenue management expertise to ensure optimal reimbursement for all types of ambulance service providers—hospital-based and municipal, reducing the significant administrative burden of billing third parties and patients. We utilize our proprietary AccessLine system to track all liquidation activity associated with ambulance accounts, and provide clients with real-time access to account information.

Reimbursement Services. Our Reimbursement services ensure that healthcare providers correctly document services which qualify for special reimbursement through the Medicare Cost Report and other governmental payment mechanisms.

Coinsurance and deductible balances constitute a significant and growing component of Medicare reimbursement. The Federal government recognizes that these balances often remain uncollected, and allows for a cost report adjustment to claim these amounts as bad debt expense; however, the reporting requirements are very demanding. Our Medicare Bad Debt reporting service accurately documents qualifying balances and assists clients in supplying all documentation required for governmental audit.

Since 1986, Medicare has allowed hospitals serving a disproportionate share of low-income patients to claim additional Federal reimbursement to offset the expense of serving this population. Again, the reporting requirements are significant, and require an increasing amount of reconciliation between the hospital's own records and government systems. Our Disproportionate Share reporting service assists hospitals in qualifying for reimbursement under this program, through the Medicare cost report related filings and professional support during audits.

Business Office Services. Our business office services encompass all or a portion of the patient accounting activities that make up a healthcare provider's revenue cycle. Such revenue cycle activities may include third-party resource identification and validation, submission of timely and accurate bills to primary and secondary payors, generation of patient statements, response to patient and third-party questions, recovery of payments due, and proper accounting for payments, contractual allowances and write-offs. These services are designed to increase the provider's revenue, improve the proportion of provider gross charges ultimately collected, accelerate cash flow, lower days in accounts receivable, and reduce administrative costs. A client may outsource one or more aspects of its patient accounting processes or may outsource the business office in its entirety. In some cases, our services are used by providers who need assistance in liquidating aged or complex accounts. At the request of a client, we are also able to provide bad debt collection services through a wholly owned subsidiary.

Customers

Health Management Systems' clients primarily consist of government healthcare and human services agencies within state and county governments. We also serve managed care plans that work with these agencies. Typically, clients award contracts for three to five year terms, and we receive contingency fees calculated as a percentage of the amounts recovered. We now have contracts with 24 states and 10 managed care plans.

Accordis' clients are public, voluntary and for-profit acute care hospitals and associated clinics, emergency medical transport agencies and large physician practices. Among Accordis' clients are the nation's three largest public health systems and the two largest emergency medical transport agencies. We engage in both multi-year and short-term engagements with our clients and substantially all of the engagements provide for contingent fees calculated as a percentage of the amounts recovered or collected for the client.

Our largest client is the Los Angeles County Department of Health Services in California. This client accounted for 10%, 12%, and 14% of our total revenue in the fiscal years ended December 31, 2004, 2003 and 2002, respectively. The loss of this customer would have a material adverse effect on Accordis and HMS Holdings Corp. We provide Los Angeles County (or designated facilities within Los Angeles County) with, among other services, secondary third-party resource identification and recovery services, commercial insurance billing services, Medi-Cal billing and follow-up services, and financial management and consulting services relating to both inpatient and outpatient accounts. Either party may terminate the agreement with or without cause upon written notice (10 days notice for Los Angeles County and 30 days notice from us), except that financial management and consulting services require 90 days written notice of termination. We provide services to this client pursuant to a contract awarded in April 2003 for a one-year period with two annual automatic renewals through June 2006. We have been providing services to this client for more than 20 years.

The clients constituting our ten largest clients change periodically. The concentration of revenue in such accounts was 59%, 63% and 56%, of our revenue in the fiscal years ended December 31, 2004, 2003 and 2002, respectively. In many instances, we provide our services pursuant to agreements subject to competitive re-procurement. All of these agreements expire between 2005 and 2008. We cannot provide any assurance that any of these agreements will be renewed and, if renewed, that the fee rates will be equal to those currently in effect.

Market Trends/Opportunities

Health Management Systems

Health Management Systems' business is defined by the nation's expensive and complex system of government-funded healthcare including entitlement programs such as Medicaid, Medicare, and programs administered by the Department of Defense and the Public Health Service. In addition, state governments operate their own programs to address the healthcare needs of their citizens. Several factors drive the financial characteristics of this market: (1) the hierarchy of programs and payors, (2) the shared funding of programs between federal and state governments, (3) the government budget and appropriations process, and (4) the steadily rising cost of healthcare in the country.

In 2003, government programs accounted for 45%, or $765 billion, of the $1.7 trillion spent on healthcare in the United States, according to CMS. Since then, government healthcare spending, especially for Medicaid, has only increased. More Americans have enrolled in the Medicaid program, bringing the total number of beneficiaries to 52 million. In calendar year 2004, Medicaid's total spending is estimated to have reached $309 billion, making Medicaid the largest healthcare payor in the country – and the program's total spending is forecast to grow at 8% to 9% annually in coming years.

In 2004, Medicaid spending also grew to become the single largest expenditure by states, larger even than education. And state Medicaid spending is expected to grow at an average of 11.7% in fiscal year 2005 – the most significant increase in recent years – according to the Kaiser Commission on Medicaid and the Uninsured. This dramatic growth is a result, in part, of the expiration of federal emergency relief in 2004. The growth far outstrips the recent progress states have made in reversing the decline of their tax revenues. No wonder that in fiscal year 2005, every state in the nation plans to implement new cost containment measures for Medicaid.

In addition, states now are preparing to take on additional costs related to the Medicare Modernization Act, which was enacted during 2004. While the Act's prescription drug benefit, which goes into effect in 2006, ultimately will alleviate some of the costs states have borne, the Act also saddles them with a host of new administrative responsibilities. Moreover, states will forego most of their potential savings by making required

"clawback" payments to the federal government. As a result, the Congressional Budget Office estimates, states will not see significant savings for years to come – and will pay a net cost of more than $1 billion in 2006.

As these fiscal pressures and government healthcare spending have grown, so too has the need for proper coordination of benefits and overpayment recovery. From the Office of Management and Budget, the Congressional Management Office and other data, it is estimated that as much as 10% of Medicaid expenditures result from over payment errors and payments where third-party liability existed.

Accordis

A number of factors are forcing healthcare providers to manage their patient accounts more efficiently. Although the aggregate Medicare and Medicaid funding received by hospitals may be growing, federal and state healthcare cost control initiatives are acting to reduce the proportion of Medicare- and Medicaid-classified hospital charges that are reimbursed by government sources. The coordination of benefits associated with ongoing changes to the eligibility for, and coverage available under, governmental, managed care, and commercial insurance programs is increasingly complex. The rising underinsured and uninsured populations pose a significant challenge especially to public hospitals, which comprise a considerable portion of our client base. As providers deliver increasingly more services in outpatient settings, their accounts receivable portfolios have become skewed toward high volume, low balance accounts, creating significantly more work for the business office staff. With the increasing complexity of the healthcare reimbursement environment and shortages of qualified labor in many areas, it is more and more difficult for an individual provider institution to maintain in-house the expertise required to operate patient accounting functions. As a result of these pressures, and as well to reduce cost, providers are now engaging outside help at an earlier stage in the revenue cycle and are seeking help in executing more of the functions of their business offices. A number have entirely outsourced the management of their patient accounting functions, as they seek to focus limited management and financial resources on the delivery of patient care.

We offer providers a cost-effective outsourcing alternative by virtue of our specialized workforce, through which we offer business office expertise, aptitude with patient accounting technology-based tools, extensive knowledge of federal, state, and local health regulations and experience in dealing with government agencies, commercial insurance companies, and others involved in administering medical assistance or insurance programs.

Competition

Health Management Systems

Health Management Systems targets federal and state healthcare programs, Medicaid managed care plans, state prescription drug programs, child support enforcement agencies, and other public programs. We compete primarily with Public Consulting Group, with large national public accounting firms, and with small regional firms specializing in one or more of our services. We compete on the basis of our dominant position in the coordination of benefits marketplace, our extensive eligibility database, our proprietary systems, historically high recovery rates, and pricing.

Accordis

Accordis competes with large computer software and systems vendors that provide healthcare business office outsourcing services (e.g., Siemens, Perot Systems, ACS, and McKesson), national collections companies (e.g., NCO Group, Inc.), large consulting and public accounting firms and with the many regional and local companies that provide accounts receivable management services.

We compete on the basis of our healthcare business office and payor program expertise, proprietary technology and systems, existing relationships, long-standing reputation in the provider market segment, and pricing.

Business Strategy

Health Management Systems

The Health Management Systems business strategy includes the following initiatives:

Grow Client Base. Health Management Systems plans to add clients by tapping the built-in demand created by the growth of government-funded healthcare. We expect our new clients to include state Medicaid programs, Medicaid managed care plans, and other state human service agencies. In addition, we intend to dedicate resources to pursuing clients within the federally funded healthcare system, such as the Medicare program and the Department of Defense TRICARE program.

Continue to Leverage Technology. In 2004, HMS implemented a variety of technology tools to streamline interaction with providers and speed the recovery of third-party costs at near-real-time. Going forward, we intend to continue using technology in innovative ways to enhance the efficiency of our efforts and improve service to clients.

Expand Our Portfolio of Services. In response to client demand, HMS plans to draw on its core competencies to expand its range of services and revenue recovery techniques. For example, we are exploring new approaches to pharmacy cost containment, as well as identification and recovery of costs related to fraud, abuse, and waste.

Expand Client Engagements. As we identify new types of opportunities for government healthcare agencies to contain costs, we expect to grow the scope of our engagements with clients. In some cases, this expansion will be incremental, accomplished through value-added services that build upon our ongoing work with clients. In other cases, we expect these engagements to migrate into full outsourcing relationships, as clients recognize the increasing need for external resources. This is the model that our work has followed in the state of Florida, where we have served as the COB outsourcer since November 2001 – and successfully renewed our contract in 2004.

Accordis

The Accordis business strategy is to offer hospitals, emergency medical transport services and other healthcare providers a comprehensive solution for their business office requirements. These Business Office services have been designed to capitalize on our extensive knowledge of federal, state, and local healthcare regulations and the healthcare business office, our experience in dealing with third-party payors, our information processing capabilities, and our specialized workforce. We distinguish our services from those offered by other vendors through our capacity to craft custom solutions, the business office and third-party claiming environment expertise of our staff, our proprietary technology and our substantial installed reference base. Additionally, our proprietary on-line information processing network, AccessLine, enables us to consolidate account information for each patient, validate account data obtained from clients through electronic links to external databases, generate claims to third parties, and organize account information in a format that facilitates cost-effective processing and recovery activities. AccessLine terminals placed onsite provide the client with instant access to individual account status.

Employees

As of December 31, 2004, we had 516 employees. No employees are covered by a collective bargaining agreement or are represented by a labor union. We believe our relations with our employees are good.

Financial Information About Industry Segments

Specific financial information with respect to our industry segments is provided in Note 14, Segments and Geographical Information, of the Notes to Consolidated Financial Statements.

Available Information

We maintain a website that contains various information about us and our services. It is accessible at www.hmsholdings.com. Through our website, shareholders and the general public may access free of charge (other than any connection charges from Internet service providers) filings we make with the Securities and Exchange Commission as soon as practicable after filing. Filing accessibility in this manner includes the Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, current reports on Form 8-K and Proxy Statements.

Item 2. Properties

Our New York City corporate headquarters consists of approximately 81,000 square feet. In addition, as of December 31, 2004, we lease approximately 146,000 square feet of office space in 17 locations throughout the United States. See Note 13(a) of the Notes to Consolidated Financial Statements for additional information about our lease commitments.

Item 3. Legal Proceedings

In April 2004, we reached an agreement with the United States Attorney's Office for the Southern District of New York to settle certain matters raised in the course of the United States Attorney's investigation of medical reimbursement claims submitted to Medicaid and other federal healthcare programs on behalf of a significant client of Accordis. In August 2004, we entered into a Stipulation and Order of Settlement and Dismissal Agreement and paid the United States government $1.35 million to settle this matter. At the same time, the *qui tam* lawsuit against us that was the basis of the government's investigation was dismissed. As part of the settlement agreement, we entered into a Compliance Agreement with the Office of the Inspector General for the Department of Health and Human Services. The Compliance Agreement covers a three-year period and principally requires us to continue our existing compliance program and to make annual filings certifying compliance.

The investigation focused on claims submitted since 1982. The issues raised by the government primarily concerned the appropriateness of completing healthcare reimbursement claims with general diagnosis information when specific diagnosis information was not available.

We recorded a charge of $1.7 million in the quarter ended March 31, 2004 to reflect the settlement and related legal and other expenses. During the quarter ended September 30, 2004, all amounts due under the settlement agreement were paid.

Other legal proceedings to which we are a party, in the opinion of our management, are not expected to have a material adverse effect on our financial position, results of operations, or liquidity.

Item 4. Submission of Matters to a Vote of Security Holders

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock is included in the Nasdaq National Market (symbol: HMSY). As of the close of business on March 25, 2005, there were approximately 6,000 holders of our common stock, including the individual participants in security position listings. We have not paid any cash dividends on our common stock and do not anticipate paying cash dividends in the foreseeable future. Our current intention is to retain earnings to support the future growth of our business.

The table below summarizes the high and low sales prices per share for our common stock for the periods indicated, as reported on the Nasdaq National Market.

	HIGH	LOW
Year ended December 31, 2004:		
Quarter ended December 31, 2004	$9.00	$6.01
Quarter ended September 30, 2004	6.78	5.19
Quarter ended June 30, 2004	6.98	5.26
Quarter ended March 31, 2004	7.49	3.88
Year ended December 31, 2003:		
Quarter ended December 31, 2003	$4.60	$2.73
Quarter ended September 30, 2003	4.02	2.57
Quarter ended June 30, 2003	3.01	2.03
Quarter ended March 31, 2003	3.80	2.00

Equity Compensation Plan Information

The following table summarizes the total number of outstanding options and shares available for other future issuances of options under all of our equity compensation plans as of December 31, 2004.

Plan Category	*Number of securities to be issued upon exercise of outstanding warrants, options and rights (a)*	*Weighted-average exercise price of outstanding warrants, options and rights (b)*	*Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a) (c)*
Equity Compensation Plans approved by Shareholders (1)	3,831,009	$3.32	1,061,566 (2)
Equity Compensation Plans not approved by Shareholders (3)	1,450,000	$1.25	-
Total	5,281,009	$2.75	1,061,566

(1) This includes options to purchase shares outstanding: (i) under the 1999 Long-Term Incentive Plan, (ii) the 1995 Non-Employee Director Stock Option Plan, and (iii) 250,000 options approved by shareholders and granted to a director in June 2002.

(2) Of these shares: (i) 988,066 shares remain available for future issuance under our 1999 Long-Term Incentive Plan, and (ii) 73,500 shares remain available for issuance under the 1995 Non-Employee Director Stock Option Plan.

(3) Options issued under plans not approved by the shareholders include (i) 750,000 options granted in January 2001 to our Chairman and Chief Executive Officer in connection with his joining us, and (ii) 700,000 options granted in March 2001 to our President and Chief Operating Officer in connection with his joining us.

Issuer Purchases of Equity Securities

On May 28, 1997, the Board of Directors authorized the Company to repurchase such number of shares of our common stock that have an aggregate purchase price not to exceed $10 million. During the year ended December 31, 2003, we repurchased 35,800 shares for $104,000. While we did not repurchase any of our common stock during the year ended December 31, 2004, we continue to evaluate repurchases under this program. At December 31, 2004, $0.7 million remains authorized for repurchases under the program.

Item 6. Selected Financial Data

SELECTED CONSOLIDATED FINANCIAL DATA (see Notes)

(In Thousands, Except Per Share Data)

	Years ended December 31,				Fiscal Year ended October 31,	Two Months ended December31,
	2004	2003	2002	2001	2000	2000
Statement of Operations Data:						
Revenue:						
Accordis	$ 41,217	$ 37,265	$ 36,331	$ 31,329	$ 42,562	$ 5,474
Health Management Systems	43,976	37,096	32,283	27,419	22,287	3,733
	85,193	74,361	68,614	58,748	64,849	9,207
Cost of services	77,690	72,481	71,656	76,818	76,520	10,895
Operating income (loss)	7,503	1,880	(3,042)	(18,070)	(11,671)	(1,688)
Gain on sale of assets	-	-	-	1,605	-	-
Net interest and net other income	323	256	517	667	1,024	138
Income (loss) from continuing operations before income taxes and cumulative effect of change in accounting principle	7,826	2,136	(2,525)	(15,798)	(10,647)	(1,550)
Income tax expense (benefit)	115	-	-	-	(4,530)	(642)
Income (loss) from continuing operations before cumulative effect of change in accounting principle	7,711	2,136	(2,525)	(15,798)	(6,117)	(908)
Discontinued operations:						
Income (loss) from discontinued operations, net	-	212	-	(5,053)	2,656	(35)
Estimated gain (loss) on disposal of discontinued operations, net	-	-	3,460	(200)	-	-
Gain on sale of discontinued operations, net	-	-	-	1,587	-	-
Discontinued operations	-	212	3,460	(3,666)	2,656	(943)
Cumulative effect of change in accounting principle, net of tax benefit	-	-	-	-	(21,965)	-
Net income (loss)	$ 7,711	$ 2,348	$ 935	$ (19,464)	$ (25,426)	(943)
Per Common Share Data:						
Basic income (loss) per share:						
From continuing operations	$ 0.40	$ 0.12	$ (0.14)	$ (0.88)	$ (0.35)	$ (0.05)
From discontinued operations	-	0.01	0.19	(0.21)	0.15	-
From change in accounting principle	-	-	-	-	(1.26)	-
Total	$ 0.40	$ 0.13	$ 0.05	$ (1.09)	$ (1.46)	$ (0.05)
Weighted average common shares, basic	19,074	18,330	18,199	17,857	17,467	17,252
Diluted income (loss) per share:						
From continuing operations	$ 0.35	$ 0.11	$ (0.14)	$ (0.88)	$ (0.35)	$ (0.05)
From discontinued operations	-	0.01	0.19	(0.21)	0.15	-
From change in accounting principle	-	-	-	-	(1.26)	-
Total	$ 0.35	$ 0.12	$ 0.05	$ (1.09)	$ (1.46)	$ (0.05)
Weighted average common shares, diluted	22,275	20,132	18,199	17,857	17,467	17,252

SELECTED CONSOLIDATED FINANCIAL DATA, continued

	December 31, 2004	December 31, 2003	December 31, 2002	December 31, 2001	December 31, 2000
Balance Sheet Data:					
Cash and short-term investments	$ 31,696	$ 26,715	$ 25,282	$ 25,042	$ 13,574
Working capital	44,147	36,197	28,625	26,238	29,055
Total assets	76,663	63,123	61,666	60,394	75,637
Shareholders' equity	60,398	50,607	47,768	45,781	64,673

Notes to Selected Consolidated Financial Data

- We adopted Staff Accounting Bulletin No. 101, Revenue Recognition in Financial Statements (SAB 101) for our fiscal year ended October 31, 2000, implementing a change in accounting in regard to revenue generated from clients seeking reimbursement from third-party payors where our fees are contingent upon the client's collections from third parties. As of November 1, 1999, we recognized revenue pertaining to such clients once the third-party payor remitted payment to our client. This policy change reduced revenue by $3.0 million and increased net loss by $0.5 million for fiscal year 2000, excluding the cumulative effect of the change. The $22.0 million cumulative effect reflects $41.7 million of unbilled receivables partially offset by $1.5 million of related direct costs and $18.2 million of income tax benefit.

  As of October 31, 1999, we had unbilled accounts receivable of $41.7 million related to our prior revenue recognition policy that had not been invoiced to clients because we were contractually obligated to invoice the client only after they received payment from the responsible third party payors. Of this amount, we subsequently recognized the following amounts in revenue and operating results:

Period	Revenue (in thousands)
Fiscal 2000	$19,346
Two months ended Dec. 31, 2000	492
Fiscal 2001	4,053
Fiscal 2002	1,062
Fiscal 2003	645
Fiscal 2004	640
	$26,238

We were unable to subsequently recognize as revenue $15.4 million of the $41.7 million in accounts receivable that were included in the cumulative effect adjustment as of November 1, 1999. The uncollectible amounts are primarily attributable to projects for state agencies that were undertaken to recoup payments from parties with prior liability for Medicaid claims. In the case of several of these projects, the state agencies, after the completion of the projects on our part (and after the recognition of revenue based on our estimate of the clients' ultimate financial recovery), made various decisions that significantly reduced the prospects for such recovery. These decisions included narrowing the scope of the completed project, implementing additional requirements prior to seeking reimbursement and, for public policy reasons in some cases, foregoing recovery of amounts otherwise reimbursable to the state agencies. The agencies took these actions over time, and it was not until the end of fiscal 2001 that it became evident that the entire $15.4 million of accounts receivable would not be realized.

As a result of the implementation of SAB 101, we were required to report in subsequent periods the amount of revenue (if material to income before income taxes) recognized in those periods that was included in the cumulative effect adjustment. Our footnote disclosure in our previously issued financial statements subsequent to the change in revenue recognition policies did not properly distinguish between amounts that were ultimately billed as revenue and amounts that were determined not to be collectable and accordingly not included in revenues. We believe that this mistake had no effect on reported earnings or cash flows on the interim or annual periods subsequent to the adoption of SAB 101.

- Discontinued Operations. In fiscal year 2001, we sold Health Care microsystems, Inc. which operated as our Decision Support Group (DSG), and implemented a formal plan to close the Payor Systems Group (PSG) through an orderly wind-down of its operations. As these two businesses were previously presented as separate reportable segments and represented separate classes of customers and major businesses, the operating results are presented as discontinued operations for all periods presented. See Note 12 of the Notes to Consolidated Financial Statements.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

Critical Accounting Policies

Revenue Recognition. We principally recognize revenue for our service offerings when third party payors remit payment to our customers. This policy is in effect because our fees are principally contingent upon our customers' collections from third parties. Due to this revenue recognition policy, our operating results may vary significantly from quarter to quarter because of the timing of such collections by our customers and the fact that a significant portion of our operating expenses are fixed.

Accounting for Income Taxes. We have incurred net operating losses for tax purposes during the five years prior to the year ended December 31, 2003 and were marginally profitable in the year ended December 31, 2003. After utilizing net operating loss carry-forwards to offset taxable income in 2004, we have cumulative federal net operating loss carry-forwards of $19.1 million as of December 31, 2004. In addition to other items expensed for financial reporting purposes that were not currently deductible for tax purposes, these net operating loss carryforwards result in gross deferred tax assets. We must assess the likelihood that the gross deferred tax assets, net of any deferred tax liabilities, will be recovered from future taxable income and to the extent we believe the recovery is not likely, we have established a valuation allowance.

Significant management judgment is required in determining this valuation allowance. We have recorded a valuation allowance of $5.6 million as of December 31, 2004, due to uncertainties related to our ability to utilize some of our net deferred tax assets, primarily consisting of certain net operating loss carry-forwards before they expire. The decrease in the valuation allowance from $8.6 million in the prior year is principally attributable to the utilization in the current year of net operating loss carryforwards to offset current year taxable income. The valuation allowance is based on our estimate of taxable income and the period over which the net deferred tax assets will be

recoverable. In the event that these estimates differ or we adjust these estimates in future periods we may need to establish an additional valuation allowance which could materially impact our financial position and results of operations.

Conversely, if we are profitable in the future at levels which cause management to conclude that it is more likely than not that we will realize all or a portion of the net deferred tax assets, for which a valuation is currently provided, we would record the estimated net realizable value of the net deferred tax asset at that time and would then provide income taxes at a rate equal to our combined federal and state effective rate of approximately 43%.

The net deferred tax asset as of December 31, 2004 was $8.9 million, which is net of a valuation allowance of $5.6 million.

Valuation of long lived and intangible assets and goodwill. Goodwill, representing the excess of acquisition costs over the fair value of net assets of acquired businesses, is not amortized but is reviewed for impairment at least annually and written down only in the periods in which it is determined that the recorded value is greater than the fair value. For the purposes of performing this impairment test, our business segments are our reporting units. The fair values of those reporting units, to which goodwill has been assigned, is compared with their recorded values. If recorded values are less than the fair values, no impairment is indicated. Since adoption, no impairment losses have been recorded.

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying value may not be recoverable. Factors we consider important which could trigger an impairment review include the following:

- Significant underperformance relative to expected historical or projected future operating results;
- Significant changes in the manner of our use of the acquired assets or the strategy for our overall business;
- Significant negative industry or economic trends;
- Significant decline in our stock price for a sustained period; and
- Our market capitalization relative to net book value.

We determine the recoverability of the carrying value of our long-lived assets based on a projection of the estimated undiscounted future net cash flows expected to result from the use of the asset. When we determine that the carrying value of long-lived assets may not be recoverable, we measure any impairment by comparing the carrying amount of the asset with the fair value of the asset. For identifiable intangibles, we determine fair value based on a projected discounted cash flow method using a discount rate reflective of our cost of funds.

Estimating valuation allowances and accrued liabilities, such as bad debts, and restructuring charges. The preparation of financial statements requires our management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reported period. In particular, management must make estimates of the uncollectability of our accounts receivable. Management specifically analyzes accounts receivable and analyzes historical bad debts, customer concentrations, customer credit-worthiness, current economic trends and changes in our customer payment terms when evaluating the adequacy of the allowance for doubtful accounts. The accounts receivable balance was $24.0 million, net of allowance for doubtful accounts of $0.9 million as of December 31, 2004.

Management has reviewed its estimates related to restructuring activities at December 31, 2004 and believes that the estimated liability is based on a reasonable assessment of the probable costs to be incurred. As additional information becomes available, we may revise the estimates. Such revisions in estimates of the potential restructuring liabilities could materially impact the results of operation and financial position.

Discontinued Operations. The accompanying financial statements are prepared using discontinued operations accounting for our discontinued DSG and PSG businesses. Under discontinued operations accounting, amounts are accrued for estimates of our expected liabilities related to discontinued operations through their eventual

discharge. In July 2001, we determined to proceed with an orderly closure of PSG by accelerating a wind-down of its remaining operations. The DSG business was sold in December 2001. At December 31, 2004, there were no remaining liabilities of the discontinued operations. Any adjustments related to costs to be incurred during the close down or losses from operations have been reflected in 2003 and 2002 as discontinued operations. In the event that any liabilities should arise from these discontinued operations, there could be a material impact on our financial position and results of operations.

New Accounting Pronouncement. On December 16, 2004, the Financial Accounting Standards Board (FASB) issued SFAS No. 123 (revised 2004), "Share-Based Payment" (SFAS No. 123R), which is a revision of SFAS No. 123, "Accounting for Stock-Based Compensation." SFAS No. 123R supercedes APB Opinion No. 25, "Accounting for Stock Issued to Employees", and amends SFAS No. 95, "Statement of Cash Flows". Generally, the approach in SFAS No. 123R is similar to the approach described in SFAS 123. However, SFAS No. 123R requires all share-based payments to employees, including grants of employee stock options, to be recognized in the income statement based on their fair values. Pro forma disclosure is no longer an alternative. SFAS No. 123R must be adopted no later than the first interim or annual period beginning after June 15, 2005.

As permitted by SFAS No. 123, we currently account for share-based payments to employees using APB Opinion No. 25's intrinsic value method and, as such, generally recognize no compensation cost for employee stock options. Accordingly, the adoption of SFAS No. 123R's fair value method will have a significant impact on our results of operations. The impact of the adoption of SFAS No. 123R cannot be determined at this time because it will depend upon levels of share-based payments granted in the future. However, had we adopted SFAS 123R in prior periods, the impact of that standard would have approximated the impact as described in the disclosure of pro forma net (loss) income and net (loss) income per share pursuant to SFAS No. 123 in Note 1 of Notes to Consolidated Financial Statements.

The above listing is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by accounting principles generally accepted in the United States of America, with no need for management's judgment in their application. There are also areas in which the audited consolidated financial statements and notes thereto included in this Form 10-K contain accounting policies and other disclosures required by accounting principles generally accepted in the United States of America.

Overview

In general, our business is driven by the consistently rising costs of healthcare in the United States. The nation's healthcare costs are expected to total $1.9 trillion in 2005, representing an increase of nearly 50% since 2000. These costs seriously affect both healthcare payors and healthcare providers, creating demand for the services we offer through our two distinct operating subsidiaries, Health Management Systems and Accordis.

Our work also is highly customized to the needs of each client, and to the specifications of individual projects. Each client engagement is unique, and requires significant up-front investment, sometimes well before the engagement generates revenue.

Ultimately, each project results in revenues and costs that must be carefully controlled. We accomplish this by striving to minimize the lead-time between project start-up and revenue generation, and by adapting common core processes to the particular needs of our clients as efficiently as possible. We also establish very specific operational metrics and profitability targets at the project level, which in turn roll up to create measurable financial objectives at the business-unit level.

The following discussion goes into further depth regarding the macroeconomic considerations that drive our revenues. The discussion of expenses then focuses on some of the factors that historically have determined the relationship between our revenues and costs.

Revenue Considerations

Revenue from our Health Management Systems business, most of which is derived from contingent fees, has grown in tandem with the rise in expenditures for entitlement programs such as Medicaid. Medicaid costs have grown by an average of approximately 10% annually over the past several years, and similar growth is expected for years to come. In addition, state governments have increasingly engaged vendors to provide coordination of benefits and cost containment services. However, there is no certainty that Health Management Systems will be successful in obtaining these contracts. In addition, it is unclear what impact the increased scrutiny of entitlement programs and the ongoing debate about healthcare reform may have on Health Management Systems' revenues.

In the provider arena, hospitals face a steady increase in the cost of providing medical care even as reimbursement from governmental and other entitlement programs is under continuous scrutiny. Given this financial pressure, we expect that hospitals will continue to delegate various business office functions to Accordis as a way of optimizing reimbursements and reducing costs for non-core activities. These activities include Medicare Bad Debt recovery, Disproportionate Share Claiming, and accounts receivable management, for which Accordis has developed technology-based solutions. As we have seen in the past year, emergency medical transport providers are also increasingly outsourcing their billing and collections to specialists in order to improve cash flow and reduce administrative costs. We expect this trend to continue. As always, however, there are no assurances that Accordis will be able to secure contracts for its services.

Finally, it should be noted that the nature of our business sometimes leads to significant variations in revenue flow. For example, since we receive contingency fees for nearly all our services, we recognize revenue only after our clients have received payment from a third party. In addition, much of our work occurs on an annual or project-specific basis, and does not necessarily recur monthly or quarterly, as our operating expenses do. See a more detailed discussion in the Risk Factors section, below.

Operating Expenses

As a service company, 50% to 55% of our operating expenses are compensation. We adjust our employee headcount based on known business needs and expectations about the near-term future. Based on recent operating results, we realize that compensation expense does tend to grow with increases in revenue – although not on a proportional basis, since many employee functions do not require additional staff as revenue increases.

Our revenue growth over the past several years has not resulted in significant changes in occupancy and data processing expenses. These expenses are largely infrastructure costs, which typically would be affected only by extraordinary growth or decline in the business, or a dramatic change in our operational delivery model.

Direct project expenses are incurred based on the requirements of each client engagement. On average, these expenses have amounted to approximately 17% to 18% of revenues annually.

Other operating expenses reflect the customary costs of doing business, such as insurance, legal fees, accounting and tax fees, and costs associated with the requirements of being a publicly traded company. Significant components of this expense category are costs of necessary external professional services, travel and entertainment, employee recruiting, training, and office materials.

Years Ended December 31, 2004 and 2003

Continuing Operations:

The following table sets forth, for the periods indicated, certain items in our Consolidated Statements of Operations expressed as a percentage of revenue:

	Years ended December 31,	
	2004	2003
Revenue	100.0%	100.0%
Cost of services:		
Compensation	51.0%	52.6%
Data processing	5.7%	6.3%
Occupancy	6.5%	7.5%
Direct project costs	16.4%	17.4%
Other operating costs	9.5%	10.3%
Restructuring costs	-	0.5%
US Attorney investigation costs	2.1%	2.9%
Total cost of services	91.2%	97.5%
Operating income	8.8%	2.5%
Net interest income	0.4%	0.4%
Income from continuing operations before income taxes	9.2%	2.9%
Income taxes	-0.1%	-
Income from continuing operations	9.1%	2.9%
Income from discontinued operations	-	0.3%
Net income	9.1%	3.2%

Operating Results

Aside from the discussion above regarding revenue fluctuations due to our revenue recognition policy and the project nature of some of our revenues, our operating expenses can increase based on discrete spending activities such as the legal fees and settlement charges we incurred in 2004 and 2003 related to the investigation by the United States Attorney's Office and in 2004, the costs associated with Sarbanes-Oxley compliance.

Revenue for the year ended December 31, 2004 was $85.2 million, an increase of $10.8 million or 14.6% compared to revenue of $74.4 million in the prior fiscal year ended December 31, 2003.

Health Management Systems, which provides third party liability identification and recovery services to state Medicaid agencies, generated revenue of $44.0 million in 2004, a $6.9 million or 18.5% increase over the prior year revenue of $37.1 million. This increase primarily reflected $1.0 million of revenue during the current year from two new state and one managed health plan clients and $0.4 million related to the expansion of services for two existing clients. In addition, revenue increased by $5.5 million across the comparable client base reflecting specific non-recurring revenue opportunities with certain clients based on their particular needs, differences in the timing of when client projects were completed in the current year compared with the prior year, and changes in the volume, yields and scope of client projects. Non-recurring revenue opportunities are generally situations where we have an opportunity to earn additional revenue from a client which we do not expect will recur in the current year or which did not exist in the prior year. There were no client terminations during 2004.

Accordis, which provides outsourced business office services for hospitals, generated revenue of $41.2 million in 2004, a $3.9 million or 10.6% increase from the prior year revenue of $37.3 million. This increase

primarily consisted of $3.6 million of revenue from seven new customers since the prior year period and a $0.8 million increase with three customers resulting from expansions in the scope of services provided. In addition, revenue increased by $2.2 million across the comparable client base reflecting specific non-recurring revenue opportunities with certain clients based on their particular needs, differences in the timing of when client projects were completed in the current year compared with the prior year, and changes in the volume, yields and scope of client projects. These increases were partially offset by a decrease in revenue of $2.7 million associated with five terminated or inactive customer relationships.

Effective November 29, 2004, our contract with George Washington University Hospital (GW) was terminated in connection with a decision by GW's parent to consolidate billing and collection activities in centralized billing offices. This contract originally had been scheduled to end June 30, 2005. As a result of this early termination, the Company and GW elected to accelerate the wind-down of services. Accordingly, by December 31, 2004, all services to GW were completed and we closed our Columbia, Maryland office. In 2004, revenue and operating margin from the GW contract were $5.8 million and $2.0 million respectively.

Operating expenses as a percentage of revenue were 91.2% in the current year compared to 97.5% in the prior year and for 2004 were $77.7 million, an increase of $5.2 million, or 7.2%, compared to prior year operating expenses of $72.5 million. The increased operating expenses in 2004 were principally due to the increases in revenue in both of the operating businesses.

Compensation expense as a percentage of revenue was 51.0% in the current year compared to 52.6% in the prior year and for 2004 was $43.4 million, an increase of $4.3 million, or 10.9% from the prior year period expense of $39.1 million. This dollar increase resulted from higher headcount, general increases in compensation rates and the cost of employee benefits. At December 31, 2004, we had 516 employees, compared to 493 employees at December 31, 2003.

Data processing expense as a percentage of revenue was 5.7% in the current fiscal year compared to 6.3% in the prior fiscal year and for 2004 was $4.9 million, an increase of $0.2 million or 4.3% compared to the prior year expense of $4.7 million. The current year increase is primarily due to increased software costs.

Occupancy expense as a percentage of revenue was 6.5% in the current year compared to 7.5% in the prior year and for 2004 was $5.5 million, a decrease of $0.1 million or 1.6% from the prior year expense of $5.6 million. This net decrease reflects the full impact of subletting one floor at our New York City headquarters and reducing office space in our Springfield, Illinois office partially offset by nominal increases in rent and other occupancy expenses.

Direct project expense as a percentage of revenue was 16.4% in the current year compared to 17.4% in the prior year and for 2004 was $14.0 million, an increase of $1.1 million or 8.2% from the prior fiscal year expense of $12.9 million. This increase reflects a $2.3 million increase in expense related to Health Management Systems partially offset by a $1.2 million decrease in expense related to Accordis. The Health Management Systems increase resulted from greater participation of subcontractors related to revenue composition and growth. The Accordis decrease was principally due to the reversal of $1.7 million in bad debt expense due to the March 2005 settlement of two accounts receivable from the District of Columbia which had been fully reserved previously, a net $1.0 million reduction in subcontractor fees based on the particular mix of client engagements, and partially offsetting increases in temporary agency and subcontractor expenses of $1.5 million associated with new business.

Other operating expenses as a percentage of revenue were 9.5% in the current year compared to 10.3% in the prior year and for 2004 were $8.1 million, an increase of $0.5 million or 6.7% compared to the prior year expense of $7.6 million. This net increase resulted from $0.8 million in expenses primarily for professional fees associated with Sarbanes-Oxley compliance partially offset by reductions of general corporate legal fees.

There were no restructuring costs in the current year, compared to $0.4 million in the prior year, reflecting an additional charge associated with higher than estimated real estate taxes on sublet office space.

Costs resulting from the United States Attorney's investigation as a percentage of revenue were 2.1% in the current year compared to 2.9% in the prior year and for 2004 were $1.8 million, a decrease of $0.4 million or 18.6% from the prior year expense of $2.2 million. This matter was settled in April 2004. See Part I, Item 3. Legal Proceedings.

Operating income for the year ended December 31, 2004 was $7.5 million compared to $1.9 million for the prior year. The Accordis operating loss was $2.1 million for the year ended December 31, 2004 compared to an operating loss of $4.6 million in the prior year. Health Management Systems had an operating profit of $9.6 million for the year ended December 31, 2004 compared to an operating profit of $6.5 million in the prior year. The decrease in the Accordis operating loss largely reflects the increase in revenue partially offset by increased compensation and direct costs expense as discussed above. The increase in Health Management Systems operating profitability largely reflects the increase in revenue partially offset by increased direct costs and compensation expense as discussed above.

In 2004, we recognized income tax expense of $115,000, principally an alternative minimum tax liability resulting from our utilization of existing net operating loss carryforwards to offset current taxable income. In 2003, we did not recognize any income tax expense or benefit against our net losses. We have incurred significant taxable losses in prior years. Most of our deferred income tax assets are in the form of net operating loss carry-forwards. A recoverability analysis was performed based on our recent taxable loss history and projections of future taxable operating results.

Net interest income of $323,000 in fiscal year 2004 compared with $256,000 in the prior year reflects an increase in market interest rates.

Income from continuing operations was $7.7 million in the current year compared with $2.1 million in the prior year. The $5.6 million increase in income largely reflects the increase in revenue partially offset by increases in operating expenses as discussed above.

Years Ended December 31, 2003 and 2002

Continuing Operations:

The following table sets forth, for the periods indicated, certain items in our Consolidated Statements of Operations expressed as a percentage of revenue:

	2003	2002
Revenue	100.0%	100.0%
Cost of services:		
Compensation	52.6%	55.1%
Data processing	6.3%	8.7%
Occupancy	7.5%	8.5%
Direct project costs	17.4%	16.8%
Other operating costs	10.3%	14.0%
Restructuring costs	0.5%	1.3%
US Attorney investigation costs	2.9%	-
Total cost of services	97.5%	104.4%
Operating income (loss)	2.5%	(4.4)%
Net interest income	0.4%	0.8%
Income (loss) from continuing operations before income taxes	2.9%	(3.6)%
Income taxes	-	-
Income (loss) from continuing operations	2.9%	(3.6)%
Income from discontinued operations	0.3%	5.0%
Net income	3.2%	1.4%

Revenue for the year ended December 31, 2003 was $74.4 million, an increase of $5.7 million or 8.4% compared to revenue of $68.6 million in the prior fiscal year ended December 31, 2002.

Health Management Systems, which provides third party liability identification and recovery services to state Medicaid agencies, generated revenue of $37.1 million in 2003, a $4.8 million or 14.9% increase over the prior year revenue of $32.3 million. This increase primarily reflected $0.5 million of revenue during the current year from two new state clients and $1.6 million related to the expansion of services for an existing client. In addition, revenue increased by $3.8 million across the comparable client base reflecting specific non-recurring revenue opportunities with certain clients based on their particular needs, differences in the timing of when client projects were completed in the current year compared with the prior year, and changes in the volume, yields and scope of client projects. Non-recurring revenue opportunities are generally situations where we have an opportunity to earn additional revenue from a client which we do not expect will recur in the current year or which did not exist in the prior year. These increases were partially offset by a $1.1 million decrease in revenue resulting from the termination of two client relationships in the prior year.

Accordis, which provides outsourced business office services for hospitals, generated revenue of $37.3 million in 2003, a $0.9 million or 2.6% increase from the prior year revenue of $36.3 million. This increase primarily consisted of $4.0 million of revenue from four new customers since the prior year period and a $2.0 million increase with four customers resulting from an expansion in the scope of services provided. These increases were partially offset by a decrease in revenue of $2.8 million across the comparable client base reflecting specific non-recurring revenue opportunities with certain clients based on their particular needs, differences in the timing of when client projects were completed in the current year compared with the prior year, and changes in the volume, yields and scope of client projects. There was also a reduction in revenue of $2.3 million associated with 12 terminated or inactive customer relationships. These decreases in revenue across the comparable client base and the decrease associated with terminated or inactive client relationships include an estimated permanent revenue loss in

the second quarter of $1.2 million attributable to processing delays and other impacts of the redirection of operational resources to regulatory matters. See Part I-Item 3. Legal Proceedings.

Operating expenses as a percentage of revenue were 97.5% in 2003 compared to 104.4% in the prior year and for 2003 were $72.5 million, an increase of $0.8 million, or 1.2%, compared to prior year operating expenses of $71.7 million. The increased operating expenses in 2003 were principally due to the increases in revenue in both of the operating businesses. As discussed below in more detail, legal fees associated with our response to the subpoena from the United States Attorney's Office were substantially offset by several non-recurring charges in 2002.

Compensation expense as a percentage of revenue was 52.6% in 2003 compared to 55.1% in the prior year and for 2003 was $39.1 million, an increase of $1.3 million, or 3.5% from the prior year period expense of $37.8 million. This dollar increase resulted from general increases in compensation rates and the cost of employee benefits. At December 31, 2003, we had 493 employees, compared to 506 employees at December 31, 2002. The current year headcount and related compensation expense reflects a shift to service center employees for the provision of business outsourcing services from higher paid information technology employees.

Data processing expense as a percentage of revenue was 6.3% in 2003 compared to 8.7% in the prior fiscal year and for 2003 was $4.7 million, a decrease of $1.1 million or 21.3% compared to the prior year expense of $6.0 million. The prior year costs included $1.3 million associated with service development and system enhancement and reconfiguration activities that were terminated in the second quarter of 2002, including a charge of $0.6 million for the disposal and impairment of hardware and software items.

Occupancy expense as a percentage of revenue was 7.5% in 2003 compared to 8.5% in the prior year and for 2003 was $5.6 million, a decrease of $0.3 million or 4.4% from the prior year expense of $5.9 million. This net decrease reflects subletting one floor at our New York City headquarters, partially offset by nominal increases in rent and other occupancy expenses.

Direct project expense as a percentage of revenue was 17.4% in 2003 compared to 16.8% in the prior year and for 2003 was $12.9 million, an increase of $1.4 million or 12.4% from the prior fiscal year expense of $11.5 million. This increase reflects a $0.9 million increase in expense related to Accordis, and a $0.5 million increase in expense related to Health Management Systems. The Accordis increase was principally due to increased subcontractor expenses of $1.2 million and $0.4 million of increased mailing costs partially offset by a $0.5 million reduction in professional fees based on the particular mix of client engagements. The increase related to Health Management Systems is consistent with a 14.9% increase in revenues.

Other operating expenses as a percentage of revenue were 10.3% in the current year compared to 14.0% in the prior year and for 2003 were $7.6 million, a decrease of $2.0 million or 20.9% compared to the prior year expense of $9.6 million. This net decrease resulted from (1) a decrease of $1.2 million primarily for consulting and professional service fees associated with a service development initiative and a system reconfiguration effort, both of which were terminated in the second quarter in 2002; (2) a decrease of $0.7 million relating to expense in the prior year period related to certain stock option grants to members of the Board of Directors; and (3) a reduction in all other expenses of $0.1 million.

Restructuring costs as a percentage of revenue were 0.5% in the current year compared to 1.3% in the prior year and in 2003 were $0.4 million, a decrease of $0.5 million from 2002. Restructuring costs in 2002 reflect: (1) an $0.8 million restructuring charge associated with reducing the amount of office space we occupy at our headquarters in New York City based on an executed sublease and (2) an additional $0.1 million in facility exit costs associated with the closure of our Washington, D.C. office. In 2003, restructuring charges reflect an additional $0.4 million associated with higher than estimated real estate taxes on sublet office space.

Costs resulting from the United States Attorney's investigation as a percentage of revenue were 2.9% or $2.2 million in 2003. There were no similar costs in 2002.

Operating income for the year ended December 31, 2003 was $1.9 million compared to an operating loss of $3.0 million for the prior year. The Accordis operating loss was $4.6 million for the year ended December 31, 2003

compared to an operating loss of $7.6 million in the prior year. Health Management Systems had an operating profit of $6.5 million for the year ended December 31, 2003 compared to an operating profit of $4.6 million in the prior year. The decrease in the Accordis operating loss largely reflects several non-recurring items in 2002 including $4.1 million in expenses for service development initiatives and system enhancement and reconfiguration activities partially offset by the $2.2 million in expenses primarily for legal fees associated with the investigation by the United States Attorney's Office. The increase in Health Management Systems operating profitability largely reflects the increase in revenue discussed above.

In 2003 and 2002, we did not recognize any income tax benefit (expense) against our income (loss) from continuing operations or the income from discontinued operations. We have incurred significant taxable losses the last several years. Most of our deferred income tax assets are in the form of net operating loss carry-forwards. A recoverability analysis was performed based on our recent taxable loss history and projections of future taxable operating results.

Net interest income of $0.3 million in fiscal year 2003 compared with $0.5 million in the prior year reflects a shift to shorter term investments and a reduction in market interest rates.

Income from continuing operations was $2.1 million in 2003 compared with a loss of $2.5 million in the prior year. The $4.6 million increase in income largely reflects the reduction of non-recurring charges, restructuring charges, asset impairments and asset write-offs during the current fiscal year discussed above as well as the effects of increased revenue, particularly in our Health Management Systems business.

Discontinued Operations

As more fully discussed in Part 1. Item 1. Business, Note 1(b) and Note 12(b) of the Notes to Consolidated Financial Statements, we reported the results of PSG and DSG as discontinued operations for all periods presented. Income from discontinued operations in 2002 of $3.5 million was principally attributable to (1) a $2.7 million termination fee which was not included in the original loss on disposal estimate for PSG, (2) a reduction in the estimated loss on disposal of PSG of $0.4 million based on actual operating results, and (3) $0.3 million resulting from the favorable resolution of certain DSG operating liabilities. Income from discontinued operations for PSG in 2003 of $0.2 million reflects the actual operating results for that period which were not previously included in the estimated loss on disposal estimate for PSG.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements.

Liquidity and Capital Resources

Historically, our principal sources of funds are operations. At December 31, 2004, our cash and cash equivalents and short-term investments and working capital were $31.7 million and $42.2 million, respectively. Although we expect that operating cash flows will be a primary source of liquidity, the current significant cash and short term investment balances and working capital position are also fundamental sources of liquidity and capital resource. The current cash and cash equivalents and short term investment balances are more than sufficient to meet our short term funding needs that are not met by operating cash flows. Operating cash flows could be adversely affected by a decrease in demand for our services. Our typical customer relationship, however, usually has a duration of several years, such that we do not expect any current decrease in demand. We estimate that we will purchase approximately $3.6 million of property and equipment during 2005, which is consistent with the amount purchased in the current year. The payments due by period for our contractual obligations, consisting principally of facility lease obligations and equipment rental and software license obligations, are as follows (in thousands):

	Total	Less than One Year	2-3 Years	4-5 Years	After 5 years
Operating leases	$34,012	$5,663	$8,781	$6,982	$12,586

We have entered into sublease arrangements for some of our facility obligations and expect to receive the following rental receipts (in thousands):

Total	Less than One Year	2-3 Years	4-5 Years	After 5 years
$7,935	$2,273	$2,429	$1,153	$2,080

For the year ended December 31, 2004, cash provided by operations was $7.0 million compared with $1.5 million for the prior year. The current year cash provided by operations of $7.0 million primarily results from $7.7 million of net income plus depreciation and amortization charges of $2.3 million, and an increase in current liabilities of $3.6 million reduced by an increase in accounts receivable of $6.7 million. During the current year, cash used in investing activities was $26.5 million reflecting the net purchase of $22.4 million in short term investments (which was reclassified to short-term investments from cash and cash equivalents), purchases of $3.7 million for property and equipment, and a $0.4 million investment in software.

Inflation

Historically, inflation has not been a material factor affecting our revenue, and general operating expenses have been subject to normal inflationary pressure. However, our business is labor intensive. Wages and other employee-related expenses increase during periods of inflation and when shortages in the skilled labor market occur. We also have a performance-based bonus plan to foster retention of and incent certain employees.

Risk Factors

PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995
SAFE HARBOR COMPLIANCE STATEMENT
FOR FORWARD-LOOKING STATEMENTS

In passing the Private Securities Litigation Reform Act of 1995 (the Reform Act), Congress encouraged public companies to make "forward-looking statements" by creating a safe harbor to protect companies from securities law liability in connection with forward-looking statements. We intend to qualify both our written and oral forward-looking statements for protection under the Reform Act and any other similar safe harbor provisions.

"Forward-looking statements" are defined by the Reform Act. Generally, forward-looking statements include expressed expectations of future events and the assumptions on which the expressed expectations are based. All forward-looking statements are inherently uncertain as they are based on various expectations and assumptions concerning future events and they are subject to numerous known and unknown risks and uncertainties which could cause actual events or results to differ materially from those projected. Due to those uncertainties and risks, prospective investors are urged not to place undue reliance on written or oral forward-looking statements of the Company. We undertake no obligation to update or revise this safe harbor compliance statement for forward-looking statements to reflect future developments. In addition, we undertake no obligation to update or revise forward-looking statements to reflect changed assumptions, the occurrence of unanticipated events or changes to future operating results over time.

We provide the following risk factor disclosures in connection with our continuing effort to qualify our written and oral forward-looking statements for the safe harbor protection of the Reform Act and any other similar safe harbor provisions. Important factors currently known to management that could cause actual results to differ materially from those in forward-looking statements include the following:

Our Operating Results Are Subject To Significant Fluctuations Due To Variability In The Timing Of When We Recognize Contingency Fee Revenue And Other Factors. As A Result, You Will Not Be Able To Rely On Our Operating Results In Any Particular Period As An Indication Of Our Future Performance

Our revenue and consequently our operating results may vary significantly from period to period as a result of a number of factors, including the loss of customers due to consolidation in the healthcare industry, fluctuations in sales activity given our sales cycle of approximately three to eighteen months, and general economic conditions as they affect healthcare providers and payors. Further, we have experienced fluctuations in our revenue of up to 25% between reporting periods due to the timing of periodic revenue recovery projects and the timing and delays in third-party payors' adjudication of claims and ultimate payment to our clients where our fees are contingent upon such collections. The extent to which future revenue fluctuations could occur due to these factors is not known and cannot be predicted. As a consequence, our results of operations are subject to significant fluctuations and our results of operations for any particular quarter or fiscal year may not be indicative of results of operations for future periods. A significant portion of our operating expenses are fixed, and are based primarily on revenue and sales forecasts. Any inability on our part to reduce spending or to compensate for any failure to meet sales forecasts or receive anticipated revenues could magnify the adverse impact of such events on our operating results.

We Are Subject To Claims If Our Service Offerings Contain Errors Or Experience Failures Or Do Not Meet Customer Expectations And Could Lose Customers And Revenue

The healthcare claiming environment is complex. On behalf of our clients, our Accordis business processes a very high volume of transactions in this environment. From time to time, we have been subject to claims by clients and could be subject to claims by clients in the future for errors in our service offerings, primarily for failures to secure reimbursement amounts otherwise payable to our clients. We have often resolved such claims by providing additional services to the client or by reducing fees on additional projects. There can be no assurance that contractual limitations of our responsibility for damages will be effective in these situations or that clients will not seek significant damages for errors in our services. Further, these performance failures could result in a loss of customers and resulting loss of revenue. In addition, service performance failures could result in a delay in market acceptance for our services, diversion of development resources, damage to our reputation or increased service costs.

The Majority Of Our Contracts With Customers May Be Terminated For Convenience

The majority of our contracts with customers are terminable upon short notice for the convenience of either party. Although to date none of our material contracts have ever been terminated under these provisions, we cannot assure you that a material contract will not be terminated for convenience in the future. Any termination of a material contract, if not replaced, could have a material adverse effect on our business, financial condition and results of operations.

We Face Significant Competition For Our Services

Competition for our services is intense and is expected to increase. Increased competition could result in reductions in our prices, gross margins and market share. We compete with other providers of healthcare information management and data processing services, as well as healthcare consulting firms. Some competitors have formed business alliances with other competitors that may affect our ability to work with some potential customers. In addition, if some of our competitors merge, a stronger competitor may emerge.

Current and prospective customers also evaluate our capabilities against the merits of their existing information management and data processing systems and expertise. Major information management systems companies, including those specializing in the healthcare industry, that do not presently offer competing services may enter our markets. Many of our competitors and potential competitors have significantly greater financial, technical, product development, marketing and other resources, and market recognition than we have. As a result, our competitors may be able to respond more quickly to new or emerging technologies, changes in customer requirements and changes in the political, economic or regulatory environment in the healthcare industry. In addition, several of our competitors may be in a position to devote greater resources to the development, promotion, and sale of their services than us.

Simplification Of The Healthcare Transfer Payment Process Could Reduce The Need For Our Services

The complexity of the healthcare transfer payment process, and our experience in offering services that improve the ability of our customers to recover incremental revenue through that process, have been contributing factors to the success our service offerings. Complexities of the healthcare transfer payment process include multiple payors, the coordination and utilization of clinical, operational, financial and/or administrative review instituted by third-party payors in an effort to control costs and manage care. If the payment processes associated with the healthcare industry are simplified, the need for our services, or the price customers are willing to pay for our services, could be reduced.

We Are Subject To Government Regulation In Our Collections Services

The collection industry in the United States is regulated both at the federal and state level. In addition to specific regulation regarding debts for healthcare services and among other collection regulations, the Federal Fair Debt Collection Practices Act (FFDCPA) regulates any person who regularly collects or attempts to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. The FFDCPA establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications and places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt. Additionally, the FFDCPA contains various notice and disclosure requirements and prohibits unfair or misleading representations by debt collectors. Many states require that we be licensed as a debt collection company and we believe that we are currently hold applicable licenses from all states where required. If we fail to comply with applicable laws and regulations, it could result in the suspension or termination of our ability to conduct collections, which would have a material adverse effect on us.

Changes In The United States Healthcare Environment Could Have A Material Negative Impact On Our Revenue And Net Income

The healthcare industry in the United States is subject to changing political, economic and regulatory influences that may affect the procurement practices and operations of healthcare organizations. Our services are designed to function within the structure of the healthcare financing and reimbursement system currently being used in the United States. During the past several years, the healthcare industry has been subject to increasing levels of governmental regulation of, among other things, reimbursement rates, certain capital expenditures, and data confidentiality and privacy. From time to time, certain proposals to reform the healthcare system have been considered by Congress. These proposals, if enacted, may increase government involvement in healthcare, lower reimbursement rates and otherwise change the operating environment for our clients. Healthcare organizations may react to these proposals and the uncertainty surrounding such proposals by curtailing or deferring their retention of service providers such as us. See also "Part 1. Item 1. Business -- Healthcare Reform and Regulatory Matters" for additional discussion on this topic. We cannot predict what impact, if any, such proposals or healthcare reforms might have on our results of operations, financial condition or business.

Recently, the General Accounting Office, an investigative arm of Congress, added Medicaid to its list of high risk programs. According to the GAO, states have used various financing schemes to generate excessive federal Medicaid matching funds while their own share of expenditures has remained unchanged or decreased. Also on January 30, 2004, the United States Senate Finance Committee Chairman requested that the HHS, CMS, and OIG respond to a lengthy request for information about vendors that provide contingency fee based revenue maximizing or revenue enhancement services to State Medicaid agencies specifically with the intent to increase federal Medicaid reimbursement. This type of service represents a very small portion of our Health Management Systems, Inc. suite of offerings and corresponding revenue streams. We cannot predict what impact, if any, this inquiry might have on our future results of operations, financial condition or business.

Our Business Is Subject To Extensive And Complex Governmental Regulations And Violations Of Any Of Those Regulations Could Result In Significant Penalties

Most of the services offered by our Accordis business involve the billing and collection of healthcare claims. These services require the interpretation and application of sometimes ambiguous reimbursement regulations under various government entitlement programs such as Medicaid and Medicare. In addition, during the past several years, federal and state governments have placed an increased emphasis on detecting and eliminating fraud and abuse in Medicare, Medicaid, and other health care programs. Violation of health care billing laws or regulations governing our services could result in the imposition of substantial civil or criminal penalties, including temporary or permanent exclusion from participation in government health care programs such as Medicare and Medicaid, and loss of customers.

The interpretation and application of the healthcare reimbursement rules to particular customer patient accounting environments involves judgment. If a regulatory agency were to disagree with certain judgments we have made or will make in providing healthcare billing services to a customer we could be subject to penalties, or fines or other sanctions by regulators. In addition, we could find it necessary to alter or eliminate some of our services.

Certain Provisions In Our Certificate Of Incorporation Could Discourage Unsolicited Takeover Attempts, Which Could Depress The Market Price Of Our Common Stock

Our certificate of incorporation authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by our Board of Directors. Accordingly, our Board of Directors is empowered, without shareholder approval, to issue preferred stock with dividend, liquidation, conversion, voting or other rights, which could adversely affect the voting power or, other rights of holders of our common stock. In the event of issuance, preferred stock could be utilized, under certain circumstances, as a method of discouraging, delaying or preventing a change in control. Although we have no present intention to issue any shares of preferred stock, we cannot assure you that we will not do so in the future. In addition, our by-laws provide for a classified Board of Directors, which could also have the effect of discouraging a change of control.

Item 7A. Quantitative and Qualitative Disclosures About Market Risks

Our holdings of financial instruments consist of municipal auction rate securities at December 31, 2004 and are classified as short-term investments and have contractual maturities between 2030 through 2044. We do not invest in portfolio equity securities or commodities or use financial derivatives for trading purposes. Our investment portfolio represents funds held temporarily, pending use in our business and operations. We manage these funds accordingly. We seek reasonable assuredness of the safety of principal and market liquidity by investing in rated fixed income securities while, at the same time, seeking to achieve a favorable rate of return. Our market risk exposure consists principally of exposure to changes in interest rates. Our holdings are also exposed to the risks of changes in the credit quality of issuers.

The table below presents the historic cost basis, and the fair value for our investment portfolio as of December 31, 2004, and the related weighted average interest rates (in thousands):

	Total Historical Cost	Total Fair Value
Municipal auction rate securities	$22,500	$22,500
Average interest rate	2.40%	

Item 8. Financial Statements and Supplementary Data

The information required by Item 8 is found on pages 32 to 53 of this report.

Item 9. Changes in and Disagreements with Independent Registered Public Accounting Firm on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures.

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the Exchange Act). Based on this evaluation, our principal executive officer and our principal financial officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this annual report.

Our principal executive officer and principal accounting officer also participated in an evaluation by our management of any changes in our internal control over financial reporting that occurred during the quarter ended December 31, 2004. That evaluation did not identify any changes that have materially affected, or are likely to materially affect, our internal control over financial reporting.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control — Integrated Framework*, our management concluded that our internal control over financial reporting was effective as of December 31, 2004.

Our independent auditors, KPMG LLP (KPMG), who have audited and reported on our financial statements, issued a report on our assessment of our internal control over financial reporting and on the effectiveness of our internal control over financial reporting. KPMG's reports are included in this annual report.

Item 9B. Other Information

None.

PART III

Item 10. Directors and Executive Officers of the Registrant

The information required by Item 10 will be included in our Proxy Statement for the 2005 Annual Meeting of Shareholders which will be mailed within 120 days after the close of our year ended December 31, 2004, and is hereby incorporated herein by reference to such Proxy Statement.

Item 11. Executive Compensation

The information required by Item 11 will be included in our Proxy Statement, which will be mailed within 120 days after the close of our year ended December 31, 2004, and is hereby incorporated herein by reference to such Proxy Statement.

Item 12. Security Ownership of Certain Beneficial Owners and Management

The information required by Item 12 will be included in our Proxy Statement, which will be mailed within 120 days after the close of our year ended December 31, 2004, and is hereby incorporated herein by reference to such Proxy Statement.

Item 13. Certain Relationships and Related Transactions

The information required by Item 13 will be included in our Proxy Statement, which will be mailed within 120 days after the close of our year ended December 31, 2004, and is hereby incorporated herein by reference to such Proxy Statement.

Item 14. Principal Accountant Fees and Services

The information required by Item 14 will be included in our Proxy Statement, which will be mailed within 120 days after the close of our year ended December 31, 2004, and is hereby incorporated herein by reference to such Proxy Statement.

PART IV

Item 15. Exhibits and Financial Statement Schedules

A. Financial Statements, Financial Statement Schedule and Exhibits

1. The financial statements are listed in the Index to Consolidated Financial Statements on page 32.
2. Financial Statement Schedule II – Valuation and Qualifying Accounts is set forth on page 54. All other financial statement schedules have been omitted as they are either not required, not applicable, or the information is otherwise included.
3. The Exhibits are set forth on the Exhibit Index on page 55.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HMS Holdings Corp.
(Registrant)

By: /s/ William F. Miller, III
William F. Miller, III
Chairman and Chief Executive Officer

Date: March 25, 2005

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signatures	Title	Date
/s/ William F. Miller, III William F. Miller, III	Chairman, Chief Executive Officer, and Director (Principal Executive Officer)	March 25, 2005
/s/ Thomas G. Archbold Thomas G. Archbold	Chief Financial Officer (Principal Financial and Accounting Officer)	March 25, 2005
/s/ Randolph G. Brown Randolph G. Brown	Director	March 25, 2005
/s/ James T. Kelly James T. Kelly	Director	March 25, 2005
/s/ William W. Neal William W. Neal	Director	March 25, 2005
/s/ Galen D. Powers Galen D. Powers	Director	March 25, 2005
/s/ Ellen A. Rudnick Ellen A. Rudnick	Director	March 25, 2005
/s/ Richard H. Stowe Richard H. Stowe	Director	March 25, 2005

HMS HOLDINGS CORP. AND SUBSIDIARIES
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Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
HMS Holdings Corp.:

We have audited the consolidated financial statements of HMS Holdings Corp. and subsidiaries as listed in the accompanying index. In connection with our audits of the consolidated financial statements, we also have audited the financial statement schedule as listed in the accompanying index. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HMS Holdings Corp. and subsidiaries as of December 31, 2004 and 2003, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2004, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of HMS Holdings Corp.'s internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated March 25, 2005 expressed an unqualified opinion on management's assessment of, and the effective operation of, internal control over financial reporting.

/s/ KPMG LLP

New York, New York
March 25, 2005

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
HMS Holdings Corp.:

We have audited management's assessment, included in the accompanying Management's Report on Internal Control Over Financial Reporting, that HMS Holdings Corp. maintained effective internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). HMS Holdings Corp.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management's assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, management's assessment that HMS Holdings Corp. maintained effective internal control over financial reporting as of December 31, 2004, is fairly stated, in all material respects, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Also, in our opinion, HMS Holdings Corp. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of HMS Holdings Corp. and subsidiaries as of December 31, 2004 and 2003, and the related consolidated statements of income, shareholders' equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2004, and our report dated March 25, 2005 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

New York, New York
March 25, 2005

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(in thousands, except share and per share amounts)

	December 31, 2004	December 31, 2003
Assets		
Current assets:		
Cash and cash equivalents	$ 9,196	$ 26,615
Short-term investments	22,500	100
Accounts receivable, net	24,049	17,331
Prepaid expenses and other current assets	3,296	3,441
Total current assets	59,041	47,487
Property and equipment, net	4,924	3,123
Goodwill, net	5,679	5,679
Deferred income taxes, net	6,939	6,551
Other assets	80	283
Total assets	$ 76,663	$ 63,123
Liabilities and Shareholders' Equity		
Current liabilities:		
Accounts payable, accrued expenses and other liabilities	$ 14,894	$ 11,290
Total current liabilities	14,894	11,290
Other liabilities	1,371	1,226
Total liabilities	16,265	12,516
Commitments and contingencies		
Shareholders' equity:		
Preferred stock - $.01 par value; 5,000,000 shares authorized; none issued	-	-
Common stock - $.01 par value; 45,000,000 shares authorized;		
20,980,331 shares issued and 19,335,415 shares outstanding at December 31, 2004;		
20,042,421 shares issued and 18,397,505 shares outstanding at December 31, 2003;	210	200
Capital in excess of par value	77,237	75,167
Accumulated deficit	(7,761)	(15,472)
Treasury stock, at cost; 1,644,916 shares at December 31, 2004		
and at December 31, 2003	(9,288)	(9,288)
Total shareholders' equity	60,398	50,607
Total liabilities and shareholders' equity	$ 76,663	$ 63,123

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME
(in thousands, except share and per share amounts)

	Year ended December 31, 2004	Year ended December 31, 2003	Year ended December 31, 2002
Revenue	$ 85,193	$ 74,361	$ 68,614
Cost of services:			
Compensation	43,421	39,140	37,834
Data processing	4,889	4,686	5,951
Occupancy	5,511	5,600	5,858
Direct project costs	13,971	12,909	11,484
Other operating costs	8,127	7,618	9,626
Restructuring costs	-	352	903
US Attorney investigation costs	1,771	2,176	-
Total cost of services	77,690	72,481	71,656
Operating income (loss)	7,503	1,880	(3,042)
Net interest income	323	256	517
Income (loss) from continuing operations before income taxes	7,826	2,136	(2,525)
Income taxes	115	-	-
Income (loss) from continuing operations	7,711	2,136	(2,525)
Income from discontinued operations, net	-	212	3,460
Net income	$ 7,711	$ 2,348	$ 935
Basic income per share data:			
Income (loss) per share from continuing operations	$ 0.40	$ 0.12	$ (0.14)
Income per share from discontinued operations	-	0.01	0.19
Net income per basic share	$ 0.40	$ 0.13	$ 0.05
Weighted average common shares outstanding, basic	19,074	18,330	18,199
Diluted income per share data:			
Income (loss) per share from continuing operations	$ 0.35	$ 0.11	$ (0.14)
Income per share from discontinued operations	-	0.01	0.19
Net income per diluted share	$ 0.35	$ 0.12	$ 0.05
Weighted average common shares, diluted	22,275	20,132	18,199

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY AND COMPREHENSIVE INCOME
(In thousands, except share amounts)

	Common Stock		Capital In Excess Of Par Value	Unearned Stock Compensation	Retained Earnings/ Accumulated Deficit	Accumulated Other Comprehensive Income/(Loss)	Treasury Stock		Note Receivable from Sale of Stock	Total Shareholders' Equity
	# of Shares Issued	Par Value					# of Shares	Amount		
Balance at December 31, 2001	19,332,089	$193	$73,550	($128)	($18,755)	($42)	1,317,016	($8,315)	($722)	$45,781
Comprehensive income:										
Net income	-	-	-	-	935	-	-	-	-	935
Change in net unrealized appreciation on short-term investments	-	-	-	-	-	50	-	-	-	50
Total comprehensive income										985
Repayment of note receivable	-	-	-	-	-	-	-	-	361	361
Shares issued under employee stock purchase plan	49,983	1	128	-	-	-	-	-	-	129
Exercise of stock options	503,318	5	710	-	-	-	-	-	-	715
Purchase of treasury stock	-	-	-	-	-	-	292,100	(869)	-	(869)
Remeasurement of unearned stock compensation	-	-	46	(46)	-	-	-	-	-	-
Stock compensation expense	-	-	525	141	-	-	-	-	-	666
Balance at December 31, 2002	19,885,390	$199	$74,959	($33)	($17,820)	$8	1,609,116	($9,184)	($361)	$47,768
Comprehensive income:										
Net income	-	-	-	-	2,348	-	-	-	-	2,348
Change in net unrealized appreciation on short-term investments	-	-	-	-	-	(8)	-	-	-	(8)
Total comprehensive income										2,340
Repayment of note receivable	-	-	-	-	-	-	-	-	361	361
Shares issued under employee stock purchase plan	17,380	-	48	-	-	-	-	-	-	48
Exercise of stock options	139,651	1	191	-	-	-	-	-	-	192
Purchase of treasury stock	-	-	-	-	-	-	35,800	(104)	-	(104)
Remeasurement of unearned stock compensation	-	-	(31)	31	-	-	-	-	-	-
Stock compensation expense	-	-	-	2	-	-	-	-	-	2
Balance at December 31, 2003	20,042,421	$200	$75,167	$ -	($15,472)	$ -	1,644,916	($9,288)	$ -	$50,607
Net and comprehensive income:	-	-	-	-	7,711	-	-	-	-	7,711
Disqualifying dispositions	-	-	41	-	0	-	-	-	-	41
Exercise of stock options	937,910	10	2,029	-	-	-	-	-	-	2,039
Balance at December 31, 2004	20,980,331	$210	$77,237	$ -	($7,761)	$ -	1,644,916	($9,288)	$ -	$60,398

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Year ended December 31, 2004	Year ended December 31, 2003	Year ended December 31, 2002
Operating activities:			
Net income	$ 7,711	$ 2,348	$ 935
Adjustments to reconcile net income to net cash provided by operating activities:			
Income from discontinued operations	-	(212)	(3,460)
Depreciation and amortization	2,251	2,555	2,518
Loss on disposal and write-off of capitalized software costs and property and equipment	31	35	693
Provision (credit) for doubtful accounts	(1,395)	300	311
Stock compensation expense	-	2	666
Changes in assets and liabilities:			
Increase in accounts receivable	(5,323)	(2,319)	(2,903)
(Increase) decrease in prepaid expenses and other current assets	(243)	135	1,213
Decrease in other assets	203	71	296
Increase (decrease) in accounts payable, accrued expenses and other liabilities	3,749	(1,382)	39
Net cash provided by operating activities	6,984	1,533	308
Investing activities:			
Purchases of property and equipment	(3,674)	(801)	(3,429)
Investment in software	(409)	-	-
Proceeds of short-term investments	(22,500)	-	-
Purchases of short-term investments	100	1,000	2,964
Net cash provided by (used in) investing activities	(26,483)	199	(465)
Financing activities:			
Proceeds from issuance of common stock	-	48	129
Proceeds from exercise of stock options	2,080	192	715
Repayment of note receivable from officer for purchase of common stock	-	361	361
Purchases of treasury stock	-	(104)	(869)
Net cash provided by financing activities	2,080	497	336
Net increase (decrease) in cash and cash equivalents	(17,419)	2,229	179
Cash and cash equivalents at beginning of period	26,615	24,174	21,020
Cash provided by discontinued operations	-	212	2,975
Cash and cash equivalents at end of period	$ 9,196	$ 26,615	$ 24,174
Supplemental disclosure of noncash investing and financing activities:			
Change in unearned compensation	$ -	(31)	46
Supplemental disclosure of cash flow information:			
Cash paid for income taxes	$ 135	$ 8	$ 215

See accompanying notes to consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

(a) Organization and Business

At a special meeting held on February 27, 2003, the shareholders of Health Management Systems, Inc. approved the creation of a holding company structure. Following that meeting, all the outstanding shares of Health Management Systems, Inc. common stock were exchanged on a one-for-one basis for the shares of common stock of HMS Holdings Corp. (the Company), the new parent company. The adoption of the holding company structure, pursuant to an Agreement and Plan of Merger approved at the shareholders meeting, constituted a reorganization with no change in ownership interests or accounting basis and no dilutive impact to the former shareholders of Health Management Systems, Inc.

HMS Holdings Corp. furnishes revenue recovery, cost containment and business office outsourcing services to healthcare providers and public health care payors. The Company helps clients increase revenue, accelerate collections, and reduce operating and administrative costs. The Company operates two businesses through its wholly owned subsidiaries, Health Management Systems, Inc. and Accordis Inc.

(b) Basis of Presentation and Principles of Consolidation

(i) Discontinued Operations of Business Segments

During 2001, the Company sold its Decision Support Group (DSG) business unit and implemented a formal plan to proceed with an orderly closure of the Payor Systems Group (PSG) business unit. In prior periods, DSG and PSG had been separate reportable segments. The historical operating results of DSG and PSG have been reported as discontinued operations in the accompanying Consolidated Statements of Operations.

(ii) Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its wholly owned subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

(c) Cash and Cash Equivalents

For purposes of financial reporting, the Company considers all highly liquid investments purchased with an original maturity of three months or less to be cash equivalents.

(d) Short-Term Investments

Short-term investments are recorded at fair value. Debt securities that the Company does not have the intent and ability to hold to maturity are classified either as "available for sale" or as "trading" and are carried at fair value. All of the Company's short-term investments are available for sale and carried at fair value. Unrealized gains and losses on securities classified as available for sale are carried as a separate component of shareholders' equity. Unrealized gains and losses on securities classified as trading are reported in earnings. Management determines the appropriate classification of its investments in debt and equity securities at the time of purchase and reevaluates such determination at each balance sheet date.

(e) Depreciation and Amortization of Property and Equipment

Property and equipment are recorded at cost. Depreciation is provided over the estimated useful lives of the property and equipment utilizing the straight-line method. Amortization of leasehold improvements is provided over the estimated useful lives of the assets or the terms of the leases, whichever is shorter, using the straight-line method. The estimated useful lives are as follows:

Equipment	3-5 years
Leasehold improvements	5-10 years
Furniture and fixtures	5-7 years

(f) Software Development Cost

The Company capitalizes certain software development costs related to software developed for internal use while in the application development stage. All other costs to develop software for internal use, either in the preliminary project stage or post implementation stage are expensed as incurred. Amortization of software development costs is calculated on a straight-line basis over the expected economic life of the product, generally estimated to be 36-48 months.

(g) Goodwill

Goodwill, representing the excess of acquisition costs over the fair value of net assets of acquired businesses, is not amortized but is reviewed for impairment at least annually and written down only in the periods in which it is determined that the recorded value is greater than its fair value. Fair value is based on a projection of the estimated discounted future net cash flows expected to result from the acquired business, using a discount rate reflective of our cost of funds. For the purposes of performing this impairment test, the Company's business segments are its reporting units. The fair values of the Company's reporting units, to which goodwill has been assigned, is compared with their recorded values. If recorded values are less than the fair values, no impairment is indicated.

(h) Long-Lived Assets

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying value of its assets to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying value of the assets exceeds the fair value of the assets and would be charged to earnings. Fair value is based on a projection of the estimated discounted future net cash flows expected to result from the asset, using a discount rate reflective of our cost of funds. Assets to be disposed of are reported at the lower of the carrying amount or fair value less the cost to sell.

(i) Income Taxes

Income taxes are accounted for under the asset and liability method. Under the asset and liability method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. This method also requires the recognition of future tax benefits for net operating loss carry-forwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as income in the period that includes the enactment date. The Company provides a valuation allowance to reduce deferred tax assets to its estimated realizable value.

(j) Net Income Per Common Share

Basic income per share is calculated by dividing net income by the weighted average number of common shares outstanding during the period. Diluted income per share is calculated by dividing net income by the weighted average number of common shares and common stock equivalents outstanding during the period. The Company had weighted average common shares and common stock equivalents outstanding during the years ended December 31, 2004, 2003 and 2002, of 19,074,000, 18,330,000 and 18,199,000, respectively for weighted average common shares, and 3,201,000, 1,802,000 and 2,254,000, respectively for common stock equivalents. In 2002, the common stock equivalents are excluded from the weighted average shares used to compute diluted net loss per share as they would be antidilutive to the per share calculation. The Company's common stock equivalents consist of stock options.

(k) Revenue Recognition

The Company recognizes revenue for its contingency fee based services when third party payors remit payments to the Company's customers and consequently the contingency is deemed to have been satisfied. This revenue recognition policy is specifically addressed in the SEC's "Frequently Asked Questions and Answers" bulletin released on October 12, 2000 pertaining to Staff Accounting Bulletin No. 101, Revenue Recognition in Financial Statements (SAB101). Transaction-related revenue is recognized based upon the completion of those transactions or services rendered during a given period.

In 2003, Staff Accounting Bulletin No. 104, Revenue Recognition (SAB 104) replaced SAB 101. The provisions of SAB 104 related to the Company's revenue recognition policy as discussed above were unchanged from SAB 101.

EITF 00-21, "Revenue Arrangements with Multiple Deliverables," requires contracts with multiple deliverables to be divided into separate units of accounting if certain criteria are met. While EITF 00-21 has not had

a material impact on the Company's financial statements, the Company applies the guidance therein and recognizes revenue on multiple deliverables as separate units of accounting if the criteria are met.

(l) Stock-Based Compensation

The Company accounts for stock-based compensation under Statement of Financial Accounting Standards (SFAS) No. 123, "Accounting for Stock-Based Compensation." As permitted by SFAS No. 123, the Company has elected to continue following the provisions of Accounting Principles Board (APB) Opinion No. 25, "Accounting for Stock Issued to Employees," and to adopt only the disclosure provisions of SFAS No. 123. Accordingly, no employee compensation costs have been recognized for its stock option plans, except as described in Note 10. Had compensation costs for the Company's stock options been determined consistent with the fair value method prescribed by SFAS 123, the Company's net income (loss) and related per share amounts would have been adjusted to the pro forma amounts indicated below:

(In thousands, except per share amounts)		Year Ended December 31, 2004	Year Ended December 31, 2003	Year Ended December 31, 2002
Net income, as reported		$ 7,711	$ 2,348	$ 935
Stock-based employee compensation expense included in reported net income		-	-	-
Total stock-based employee compensation expense determined under fair value based method for all awards, net of related tax effects		$ (1,363)	$ (2,403)	$ (1,686)
Pro forma net income (loss)		$ 6,348	$ (55)	$ (751)
Net income (loss) per basic share:	As reported	$ 0.40	$ 0.13	$ 0.05
	Pro forma	$ 0.33	$ -	$ (0.04)
Net income (loss) per diluted share:	As reported	$ 0.35	$ 0.12	$ 0.05
	Pro forma	$ 0.28	$ -	$ (0.04)

The effect presented above by applying the disclosure-only provisions of SFAS 123 may not be representative of the pro forma effect in future years.

The weighted average fair value of the stock options granted for the years ended December 31, 2004, 2003, and 2002 were $3.87, $1.69 and $1.82, respectively. The fair value of the stock options granted in the years ended December 31, 2004, 2003 and 2002 is estimated at the grant date using the Black-Scholes option-pricing model with the following assumptions: dividend yield of 0% (the Company does not pay dividends); expected volatility of 62.3%, 61.1% and 65.1%; a risk-free interest rate of 4.03%, 3.25% and 2.8%, and expected lives of 5.98, 5.97 and 4.69 years, respectively.

(m) Fair Value of Financial Instruments

The carrying amounts for the Company's cash equivalents, short-term investments, accounts receivable, and accounts payable approximate fair value due to their short-term nature. The fair market value for short-term securities is based on quoted market prices where available.

(n) Comprehensive Income

Other comprehensive income recorded by the Company is comprised of unrealized gains and losses on short-term investments.

(o) Use of Estimates

The preparation of the consolidated financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reported period. The actual results could differ from those estimates.

(p) Reclassifications

Certain reclassifications were made to prior year amounts to conform to the current presentation.

(q) New Accounting Pronouncement

On December 16, 2004, the Financial Accounting Standards Board ("FASB") issued SFAS No. 123 (revised 2004), "Share-Based Payment" ("SFAS No. 123R"), which is a revision of SFAS No. 123, "Accounting for Stock-Based Compensation." SFAS No. 123R supercedes APB Opinion No. 25, "Accounting for Stock Issued to Employees", and amends SFAS No. 95, "Statement of Cash Flows". Generally, the approach in SFAS No. 123R is similar to the approach described in SFAS 123. However, SFAS No. 123R requires all share-based payments to employees, including grants of employee stock options, to be recognized in the income statement based on their fair values. Pro forma disclosure is no longer an alternative. SFAS No. 123R must be adopted no later than the first interim or annual period beginning after June 15, 2005.

As permitted by SFAS No. 123, we currently account for share-based payments to employees using APB Opinion No. 25's intrinsic value method and, as such, generally recognize no compensation cost for employee stock options. Accordingly, the adoption of SFAS No. 123R's fair value method will have a significant impact on our results of operations. The impact of the adoption of SFAS No. 123R cannot be determined at this time because it will depend upon levels of share-based payments granted in the future. However had we adopted SFAS 123R in prior periods, the impact of that standard would have approximated the impact as described in the disclosure of pro forma net (loss) income and net (loss) income per share pursuant to SFAS No. 123 in Note 1. (l) of Notes to Consolidated Financial Statements.

2. Short-Term Investments

The table below presents the historical cost basis, and the fair value for the Company's investment portfolio at December 31, 2004 and 2003 (in thousands):

	Historical Cost	Fair Value
December 31, 2004: Municipal Auction Rate Securities	$ 22,500	$ 22,500
December 31, 2003: Fixed Income Governmental Securities	$ 100	$ 100

The Company's holdings of short-term investments at December 31, 2004 consist of municipal auction rate securities of high credit quality and have contractual maturities between 2030 and 2044. All such instruments are classified as securities available for sale.

3. Accounts Receivable

(a) Amounts due from the District of Columbia

In 2001, the Company recognized bad debt expense in the total amount of $2.7 million for the full amount of outstanding accounts receivable from the District. This $2.7 million of accounts receivable consisted of $1.6 million for retroactive Disproportionate Share Hospital (DSH) revenue recovery services for the D.C. Medicaid program, and $1.1 million for retroactive Medicaid rate adjustment services rendered to D.C. General Hospital, which amount was included in the allowance for doubtful accounts at December 31, 2003.

On March 8, 2005, the Company received $2.4 million in settlement of two accounts receivable from the District of Columbia (the District or DC) and also recognized contingent recovery fees and settlement expenses approximating $0.7 million resulting from this settlement. Although this settlement was negotiated and received subsequent to December 31, 2004, the Company reflected it in the 2004 results of operations as the subsequent settlement of this litigation eliminated the need for a bad debt allowance against these accounts receivable at December 31, 2004. Accordingly, the Company adjusted accounts receivable at December 31, 2004 to $2.4 million, the amount of the settlement, and reduced bad debt expense by $1.7 million, which is included in direct project costs.

(b) Allowance for Doubtful Accounts

Accounts receivable are reflected net of an allowance for doubtful accounts of $0.9 million and $3.5 million at December 31, 2004 and 2003, respectively. The reduction in the allowance for doubtful accounts is primarily due to the $2.7 million reduction resulting from the DC settlement discussed above.

4. Property and Equipment

Property and equipment as of December 31, 2004 and 2003 consisted of the following (in thousands):

	December 31, 2004	December 31, 2003
Equipment	$ 12,779	$ 10,697
Leasehold improvements	4,361	4,252
Furniture and fixtures	4,328	4,163
	21,468	19,112
Less accumulated depreciation and amortization	(16,544)	(15,989)
Property and equipment, net	$ 4,924	$ 3,123

Depreciation and amortization expense related to property and equipment charged to operations for the years ended December 31, 2004, 2003 and 2002, was $2.3 million, $2.6 million and $2.5 million, respectively.

5. Goodwill

Goodwill as of December 31, 2004 and 2003 was $5.7 million.

Effective January 1, 2002, the Company adopted SFAS 142. SFAS 142 eliminates amortization of goodwill and indefinite-lived intangible assets, addresses the amortization of intangible assets with finite lives and addresses impairment testing and recognition for goodwill and intangible assets. As a result of adoption, amortization ceased for goodwill. Since adoption, no impairment losses have been recorded.

6. Accounts Payable, Accrued Expenses and Other Liabilities

Accounts payable, accrued expenses and other liabilities as of December 31, 2004 and 2003 consisted of the following (in thousands):

	2004	2003
Accounts payable, trade	$ 4,871	$ 2,722
Accrued compensation	4,500	3,845
Accrued direct project costs	1,908	1,399
Accrued restructuring costs	1,337	1,442
Accrued software license obligations	-	441
Accrued legal fees	800	325
Accrued other expenses	1,478	1,116
	$ 14,894	$ 11,290

As of December 31, 2004 and 2003, $1.1 million and $1.0 million, respectively, were included in other liabilities (long-term) related to the Company's recognizing of rental expenses on the Company's facility leases on a straight-line basis.

7. Income Taxes

The current income tax expense for the periods applicable was allocated as follows (in thousands):

	Year Ended December 31, 2004	Year Ended December 31, 2003	Year Ended December 31, 2002
Federal tax expense	$ 80	$ -	$ -
State tax expense	35		
Total tax expense	$ 115	$ -	$ -

The current income tax expense in 2004 principally arises from Alternative Minimum Tax requirements. There was no income tax expense (benefit) from continuing operations for the years ended December 31, 2003 and 2002.

A reconciliation of the income tax expense (benefit) calculated using the applicable federal statutory rates to the actual income tax expense (benefit) from continuing operations follows (in thousands):

	Years Ended December 31,					
	2004	%	2003	%	2002	%
Income tax expense (benefit):						
Computed at federal statutory rate	$ 2,661	34.0	$ 726	34.0	$ (859)	(34.0)
State and local tax expense, net of federal benefit	619	7.9	196	9.2	(171)	(6.8)
Municipal interest	-	-	(4)	(0.2)	(48)	(1.9)
Increase (decrease) in valuation allowance	(3,055)	(39.0)	(1,142)	(53.5)	1,412	55.9
Benefit of subsidiary merger	-	-	-	-	(330)	(13.0)
Other, net	(110)	(1.4)	224	10.5	(4)	(0.2)
Total income tax expense (benefit)	$ 115	1.5	$ -	-	$ -	-

Deferred income taxes are recognized for the future tax consequences of temporary differences between the financial statement and tax bases of assets and liabilities. The tax effect of temporary differences that give rise to a significant portion of the deferred tax assets and deferred tax liabilities at December 31, 2004 and 2003 were as follows (in thousands):

	December 31, 2004	December 31, 2003
Deferred tax assets:		
Allowance for doubtful accounts	$ 659	$ 1,675
Property and equipment	916	1,230
Restructuring cost	723	873
Goodwill and other intangibles	1,095	1,342
Software	534	631
Federal and state net operating loss carryforwards	9,195	10,867
Deferred stock compensation	417	338
Deferred rent	441	271
Other	669	334
Total deferred tax assets before valuation allowance	14,649	17,561
Less valuation allowance	(5,557)	(8,612)
Total deferred tax assets after valuation allowance	9,092	8,949
Deferred tax liabilities:		
Capitalized research and development cost	172	29
Total deferred tax liabilities	172	29
Total net deferred tax assets	$ 8,920	$ 8,920
Net current deferred tax assets	$ 1,981	$ 2,369
Net non-current deferred tax assets	6,939	6,551
Total net deferred tax assets	$ 8,920	$ 8,920

At December 31, 2004, the Company had net operating loss carry-forwards of $19.1 million and $32.9 million, which are available to offset future federal and state/local taxable income, respectively. Of the federal amount, $1.6 million is subject to annual limitation of $266,000 under Internal Revenue Code Section 382. The federal and state/local net operating loss carry-forwards expire between years 2008 through 2023. In addition, approximately $2.9 million of the federal and state net operating loss and $1.2 million of the valuation allowance (tax effected) pertains to stock option exercises for which any subsequent utilization will be recorded as an adjustment to additional paid-in capital.

During the year ended December 31, 2003, the Company recognized a decrease in the valuation allowance of $1.2 million related to the Company's ability to realize its deferred tax assets. During the year ended December 31, 2004, the Company recognized a decrease in the valuation allowance of $3.1 million principally related to the Company's utilization of net operating loss carry-forwards (NOLs) to offset 2004 income. The resultant valuation allowance balance of $5.6 million is specifically associated with the Company's NOLs, which account for the majority of the Company's deferred tax assets. The Company believes the available objective evidence, principally its recent taxable losses, creates sufficient uncertainty regarding the realizability of its NOLs, that it is more likely than not, that some of the NOLs are not realizable. The Company determined the amount of the valuation allowance based on its assessment of the recoverability of the deferred tax assets by projecting future taxable income. The projection included the reversal of known temporary differences, and reflected managements' estimates of future results of operations after considering the significant changes in the Company's business represented by the business divestitures, sales of assets, and operational and infrastructure restructurings as discussed in Note 12. The realizability of the Company's deferred tax assets and the corresponding valuation allowance will be adjusted in the future based on the Company's actual taxable income results and updated estimates of future taxable income. The Company believes that it is more likely than not that the results of future operations will generate sufficient taxable income to realize the deferred tax assets, net of valuation allowance, based on its projection of future operating results.

8. Equity

(a) Common Stock

The terms of the Company's authorized capital are identical in all material respects to the terms of Health Management Systems, Inc. authorized capital stock prior to the shareholder approval of the holding company structure.

(b) Treasury Stock

On May 28, 1997, the Board of Directors authorized the Company to repurchase such number of shares of its common stock that have an aggregate purchase price not to exceed $10 million. The Company is authorized to repurchase these shares from time to time on the open market or in negotiated transactions at prices deemed appropriate by the Company. Repurchased shares are deposited in the Company's treasury and used for general corporate purposes. During the year ended December 31, 2004, the Company did not repurchase any shares of common stock. During the year ended December 31, 2003, the Company repurchased a total of 35,800 shares of common stock for $104,000 at an average price of $2.93 per share. During the year ended December 31, 2002, the Company repurchased a total of 292,100 shares of common stock for $869,000 at an average price of $2.97 per share. Since the inception of the repurchase program in June 1997, the Company has repurchased 1,644,916 shares of common stock at an average price of $5.65 per share having an aggregate purchase price of $9.3 million.

(c) Preferred Stock

The Company's certificate of incorporation, as amended, authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by the Company's Board of Directors. As of December 31, 2004 no preferred stock had been issued.

9. Employee Benefit Plan

The Company sponsors a benefit plan to provide retirement benefits for its employees known as the HMS Holdings Corp. 401(k) Plan (the 401(k) Plan). Participants may make voluntary contributions to the 401(k) Plan of up to 60% of their annual base pre-tax compensation not to exceed the federally determined maximum allowable contribution. The 401(k) Plan permits discretionary Company contributions. The Company contributions are not in the form of the Company's common stock and participants are not permitted to invest their contributions in the Company's stock. For the years ended December 31, 2004, 2003 and 2002 the Company contributions to the 401(k) Plan were $609,000, $467,000, and $451,000, respectively.

10. Stock-Based Compensation Plans

(a) 1999 Long-Term Incentive Plan

The Company's 1999 Long-Term Incentive Stock Plan (the Plan), was approved by the Company's shareholders at the Annual Meeting of Shareholders held on March 9, 1999. The primary purposes of the Plan are (i) to promote the interests of the Company and its shareholders by strengthening the Company's ability to attract and retain highly competent individuals to serve as Directors, officers and other key employees and (ii) to provide a means to encourage stock ownership and proprietary interest by such persons. The Plan provides for the grant of (a) options to purchase shares of the Company's common stock at an exercise price no less than 100% of the fair market value of the Company's common stock; (b) stock appreciation rights (SAR) representing the right to receive a payment, in cash, shares of common stock, or a combination thereof, equal to the excess of the fair market value of a specified number of shares of the Company's common stock on the date the SAR is exercised over the fair market value of such shares on the date the SAR was granted; or (c) stock awards made or valued, in whole or in part, by reference to shares of common stock. Options are granted under the Plan with various vesting provisions up to five years, including time based and/or performance based vesting periods. Stock options currently outstanding become exercisable and expire at various dates through April 2014. Options expire ten years after the date of grant. As of December 31, 2004, no SAR's or stock purchase awards had been granted. At the June 4, 2003 Annual Meeting of Shareholders, the shareholders approved an increase in the number of shares of common stock available for issuance

under the Plan to 6,251,356 from 4,751,356. The Plan expires in January 2009. As of December 31, 2004, there were approximately 988,000 options available for grant under the Plan.

On December 15, 2000, two members of the Board of Directors were each granted 100,000 options under the Plan for additional consulting service beyond their status as board members for participation in the Company's strategic review, divestiture assessment and operational re-engineering. The Company therefore recognized compensation expense for these options using variable stock option accounting. Based on the fair value of the options using the Black-Scholes option pricing model, the Company recorded stock compensation expense totaling $2,000 and $141,000 for the years ended December 31, 2003 and 2002, respectively, as a component of other operating costs in the accompanying Consolidated Statements of Income.

(b) 1995 Non-Employee Director Stock Option Plan

The Company's 1995 Non-Employee Director Stock Option Plan (the NEDP) was adopted by the Board of Directors on November 30, 1994. Under the NEDP, directors of the Company who are not employees of the Company or its subsidiaries may be granted options to purchase 1,500 shares of common stock of the Company during the fourth quarter of each year commencing with fiscal year 1995. Options for the purchase of up to 112,500 shares of common stock may be granted under the NEDP and the Company will reserve the same number of shares for issuance. The options available for grant are automatically increased to the extent any granted options expire or terminate unexercised. The last awards under the NEDP were in October 2000. As of December 31, 2004 and 2003, 36,000 and 39,000 options were outstanding, respectively. As of December 31, 2004, there were approximately 74,000 options available for grant under the NEDP.

(c) Options Issued Outside the Plans

On June 4, 2002, as ratified by the shareholders at the Company's annual meeting, the Company granted 250,000 stock options at an exercise price of $2.48 per share to a member of the Board of Directors. All of the options were fully vested on the grant date, June 4, 2002. This grant represented 60,000 options for service as a board member consistent with a similar grant to the other board members in December 2001, and 190,000 options as an inducement to join the board. The Company immediately recognized a total of $525,000 in compensation expense consisting of $478,800 based on the fair value of the options using the Black-Scholes option pricing model for the 190,000 options and $46,200 for the 60,000 options based on the difference between the current market price of the stock on the grant date and the exercise price.

(d) Summary of Options

Presented below is a summary of the Company's options for the years ended December 31, 2004, 2003 and 2002 (in thousands, except per share amounts):

	December 31, 2004		December 31, 2003		December 31, 2002	
	Shares	Weighted average exercise price	Shares	Weighted average exercise price	Shares	Weighted average exercise price
Outstanding at beginning of period	6,336	$2.68	5,625	$2.65	5,782	$2.76
Granted	50	6.39	980	2.97	1,448	3.32
Exercised	(938)	2.17	(140)	1.38	(503)	1.42
Cancelled	(167)	4.15	(129)	5.05	(1,102)	4.66
Outstanding at end of period	5,281	$2.75	6,336	$2.68	5,625	$2.65
Weighted average fair value of options granted (Black-Scholes)		$3.87		$1.69		$1.82

The following table summarizes information for stock options outstanding at December 31, 2004 (in thousands, except per share data):

Range of exercise prices	Number outstanding as of December 31, 2004	Weighted average remaining contractual life	Weighted average exercise price	Number exercisable	Weighted average exercise price
$1.07	315	5.96	$1.07	315	$1.07
1.19	700	6.24	1.19	700	1.19
1.27-1.31	775	6.04	1.31	775	1.31
1.50 - 1.96	227	6.57	1.73	227	1.73
2.48	905	7.08	2.48	905	2.48
2.76-2.92	571	8.83	2.91	365	2.91
3.05 - 3.10	193	8.70	3.06	122	3.05
3.41	812	7.97	3.41	812	3.41
3.55-5.88	316	5.59	4.70	211	4.89
6.32 - 23.00	467	4.22	6.89	425	6.93
$1.07 - $23.00	5,281	6.77	$2.75	4,857	$2.68

(e) Employee Stock Purchase Plan

For the years ended December 31, 2003 and 2002 employees purchased 17,380 and 49,983, respectively, of common stock pursuant to the Health Management Systems, Inc. Employee Stock Purchase Plan (the ESPP) for aggregate consideration of $48,000 and $129,000, respectively.

As of December 31, 2002, the ESPP was discontinued as substantially all of the shares reserved for issuance by the Board of Directors had been issued. Shares issued in 2003 were purchased with amounts withheld from employees in 2002.

11. Transactions with Officers and Other Related Parties

(a) Transactions with Chief Executive Officer

As a condition of joining the Company, the Chief Executive Officer was provided financing to acquire 550,000 common shares directly from the Company at $1.31 per share, the then current market price. In January 2001, the Company's former Accelerated Claims Processing, Inc. subsidiary, a Delaware corporation, provided this financing, in the form of a full recourse note in the amount of $722,000, bearing interest at the rate of 6.5% per annum, payable in two equal annual installments commencing January 2002. The first installment of $361,000 in principal and $46,000 in interest was received in January 2002. The second and final installment of $361,000 in principal and $24,000 in interest was received in January 2003. The sale of common stock was exempt from the registration provisions of the Securities Act of 1933, as amended, pursuant to Section 4(2) of that Act relating to transactions not involving a public offering.

(b) Separation Agreement with Former Chief Executive Officer

Pursuant to the terms of a Separation Agreement executed in October 2000, the Company provided separation compensation to the former Chief Executive Officer of $1.5 million and an additional payment of $150,000 in exchange for his non-compete through April 2006. The agreement also provides for full salary continuation for two years at an annual rate of $364,000, a consulting arrangement for $50,000 per year thereafter until April 2006, and health insurance coverage for the related periods. As of December 31, 2004 and 2003, $90,000 and $152,000, respectively, remained as liabilities pursuant to the terms of the agreement.

(c) Related Party Transactions

The Company incurred approximately $259,000, $89,000 and $61,000 for the years ended December 31, 2004, 2003 and 2002, respectively, in fees to a law firm at which one director of the Company is a senior partner.

The 2004 amounts include contingent fees of approximately $235,000 incurred in connection with the settlement of the DC litigation discussed in Note 3.

12. Restructurings and Discontinued Operations

(a) Restructurings

In December 2001, the Company recognized a restructuring charge of $1.8 million consisting of $1.3 million for facility costs associated with reducing the amount of space the Company occupies at its headquarters in New York City, and $500,000 for severance costs associated with reducing 20 employees in the information technology and facilities maintenance departments. In December 2002, the Company increased this restructuring charge by $800,000 for additional facilities costs associated with reducing its New York City office space based on an executed sublease. In December 2003, the Company increased this restructuring charge by $352,000 reflecting higher than forecasted real estate taxes. As of December 31, 2004 and 2003, $1.3 million and $1.4 million respectively, remained as accrued liabilities.

The following table presents a summary of the activity in accrued liabilities for restructuring charges (in thousands):

	New York Leased Space Reduction
Balance at December 31, 2002	$2,088
Cash payments	(999)
Provision	352
Balance at December 31, 2003	1,441
Cash payments	(104)
Provision	-
Balance at December 31, 2004	$1,337

(b) Discontinued Operations of Business Segments

(i) Discontinuance of Payor Systems Group

In 2001, the Company implemented a formal plan to proceed with an orderly closing of its Payor Systems Group (PSG). The Company's formal plan of discontinuance included provisions for on-going service to existing clients according to the current contract terms while pursuing early release from existing contract relationships or opportunities to assign the contracts to other service providers. In 2002, the Company received a $2.7 million termination fee, which was not included in the disposal estimate. In addition, the Company reduced the estimated loss on disposal by $448,000, based on actual operating results from 2002. Consequently, the Company recognized income from discontinued operations, in the accompanying Consolidated Statement of Operations, of $3.1 million in 2002. In 2003, based on the actual results of operations, the Company recognized $212,000 of income from discontinued operations.

(ii) Sale of Decision Support Group

In 2001, the Company sold its healthcare decision support software systems and services business, Health Care microsystems, Inc. (HCm), a wholly owned subsidiary, which operated as the Company's Decision Support Group (DSG) business segment, to HCm's executive management team, resulting in a gain of $1.6 million. In 2002, the Company increased the estimated gain on the disposal of this segment by $311,000, resulting from the favorable resolution of certain operating liabilities.

13. Commitments and Contingencies

(a) Lease commitments

The Company leases office space, data processing equipment and software licenses under operating leases that expire at various dates through 2013. The lease agreements provide for rent escalations. Rent expense, net of sublease income, for the years ended December 31, 2004, 2003 and 2002, was $3.6 million, $3.4 million and $4.5 million, respectively. Sublease income was $1.1 million, for the years ended December 31, 2004, 2003 and 2002.

Minimum annual lease payments to be made and sublease payments to be received for each of the next five years ending December 31 and thereafter are as follows (in thousands):

Year	Payments	Sublease Receipts
2005	$5,663	$2,273
2006	4,706	1,477
2007	4,075	952
2008	3,500	571
2009	3,482	582
Thereafter	12,586	2,080
Total	$ 34,012	$7,935

(b) Legal

In April 2004, the Company reached an agreement with the United States Attorney's Office for the Southern District of New York to settle certain matters raised in the course of the United States Attorney's investigation of medical reimbursement claims submitted to Medicaid and other federal healthcare programs on behalf of a significant client of Accordis. In August 2004, the Company entered into a Stipulation and Order of Settlement and Dismissal Agreement and paid the United States government $1.35 million to settle this matter. At the same time, the *qui tam* lawsuit against the Company that was the basis of the government's investigation was dismissed. As part of the settlement agreement, the Company entered into a Compliance Agreement with the Office of the Inspector General for the Department of Health and Human Services. The Compliance Agreement covers a three-year period and principally requires the Company to continue its existing compliance program and to make annual filings certifying compliance.

The investigation focused on claims submitted since 1982. The issues raised by the government primarily concerned the appropriateness of completing healthcare reimbursement claims with general diagnosis information when specific diagnosis information was not available.

The Company recorded a charge of $1.7 million in the quarter ended March 31, 2004 to reflect the settlement and related legal and other expenses. During the quarter ended September 30, 2004, all amounts due under the settlement agreement were paid.

Other legal proceedings to which the Company is a party, in the opinion of the Company's management, are not expected to have a material adverse effect on the Company's financial position, results of operations, or liquidity.

(c) Employment Agreements

The Company is obligated under a separation agreement with a former executive as further presented in Note 11(b). In addition, the Company is obligated under three employment agreements with executive officers that provide for salary and benefit continuation in the event of termination without cause, that expire in January 2006, October 2006 and April 2007.

14. Segments and Geographical Information

In June 1997, the FASB issued SFAS No. 131, "Disclosures About Segments of An Enterprise and Related Information." SFAS No. 131 established standards for reporting information about operating segments in annual financial statements and in interim financial reports issued to stockholders.

(a) Segment Information

Accordis provides business office outsourcing services for hospitals, emergency medical transport agencies, and other healthcare providers. These business office services may include identifying third-party resources, submitting timely and accurate bills to third-party payors and patients, recovering and properly accounting for the amounts due, responding to customer service questions from patients, and securing the appropriate cost-based reimbursement from entitlement programs. Clients may outsource the entirety of their business office operations to us, or discrete components of the revenue cycle.

Health Management Systems works on behalf of government healthcare programs to contain costs by recovering expenditures that were the responsibility of a third party, or that were paid inappropriately. Health

Management Systems' clients include state and county Medicaid programs, their managed care plans, state prescription drug programs, child support enforcement agencies, and other public programs. By assisting these agencies in properly accounting for the services they deliver, we also help ensure that they receive the full amount of program funding to which they are entitled. The Company measures the performance of its operating segments through "Operating Income" as defined in the accompanying Consolidated Statements of Operations.

(in thousands)	Total HMS Holdings continuing opertations	Accordis	Health Management Systems	Corporate
Year ended December 31, 2004				
Revenue	$85,193	$41,217	$43,976	$ -
Operating income (loss)	7,503	(2,073)	9,576	-
Total assets	76,663	19,991	16,056	40,616
Goodwill	5,679	4,596	1,083	-
Depreciation and amortization	2,251	1,119	1,132	-
Capital expenditures and software capitalization	4,083	1,805	2,278	-
Year ended December 31, 2003				
Revenue	$74,361	$37,265	$37,096	$ -
Operating income (loss)	1,880	(4,599)	6,479	-
Total assets	63,123	15,783	11,705	35,635
Goodwill	5,679	4,596	1,083	-
Depreciation and amortization	2,555	1,293	1,262	-
Capital expenditures and software capitalization	801	320	481	-
Year ended December 31, 2002				
Revenue	68,614	36,331	32,283	-
Operating income (loss)	(3,042)	(7,641)	4,599	-
Total assets	61,666	16,637	10,827	34,202
Goodwill	5,679	4,596	1,083	-
Depreciation and amortization	2,518	1,327	1,191	-
Capital expenditures and software capitalization	3,429	1,923	1,506	-

Assets, including prepaid expenses, property and equipment and goodwill have been allocated to identified segments based upon actual usage, occupancy or other correlations with operating metrics. Other corporate assets, including cash, short-term investments, and deferred tax assets, are shown in the corporate category.

(b) Geographic Information

The Company operates within the continental United States.

(c) Major Customers

The Company's largest client is the Los Angeles County Department of Health Services in California. This client accounted for 10%, 12% and 14% of the Company's total revenue in the years ended December 31, 2004, 2003 and 2002, respectively. The loss of this customer would have a material adverse effect on Accordis and HMS Holdings Corp. The Company provides the County (or designated facilities within the County) with, among other services, secondary third-party resource identification and recovery services, commercial insurance billing services, Medi-Cal billing and follow-up services, and financial management and consulting services relating to both inpatient and outpatient accounts. Either party may terminate the agreement with or without cause upon 30 days written notice, except that financial management and consulting services require 90 days written notice of termination. The Company provides services to this client pursuant to a contract awarded in April 2003 for a one-year period with two annual automatic renewals through June 2006. Although the Company cannot give any assurance that the contract will be renewed after June 2006. The Company has been providing services to this client for more than 20 years.

(d) Concentration of Revenue

The clients constituting the Company's ten largest clients change periodically. The concentration of revenue with such clients was 59%, 63% and 56% of the Company's revenue in the years ended December 31, 2004, 2003 and 2002 respectively. In many instances, the Company provides its services pursuant to agreements subject to competitive re-procurement. All of these agreements expire between 2005 and 2007. The Company cannot provide assurance that any of these agreements will be renewed and, if renewed, that the fee rates will be equal to those currently in effect.

15. Change in Accounting Principle for Revenue Recognition

The Company adopted Staff Accounting Bulletin No. 101, Revenue Recognition in Financial Statements (SAB 101) for its fiscal year ended October 31, 2000, implementing a change in accounting in regard to revenue generated from clients seeking reimbursement from third-party payors where its fees are contingent upon the client's collections from third parties.

As of October 31, 1999, the Company had unbilled accounts receivable of $41.7 million related to its prior revenue recognition policy that had not been invoiced to clients because the Company was contractually obligated to invoice the client only after they received payment from the responsible third party payors. Of this amount, the Company subsequently recognized $0.6 million, $0.6 million and $1.1 million during fiscal years 2004, 2003 and 2002, respectively and $23.9 million during fiscal years prior to 2002.

The Company was unable to subsequently recognize as revenue $15.4 million of the $41.7 million in accounts receivable that were included in the cumulative effect adjustment as of November 1, 1999. The uncollectible amounts are primarily attributable to projects for state agencies that were undertaken to recoup payments from parties with prior liability for Medicaid claims. In the case of several of these projects, the state agencies, after the completion of the projects by the Company (and after the recognition of revenue based on our estimate of the clients' ultimate financial recovery), made various decisions that significantly reduced the prospects for such recovery. These decisions included narrowing the scope of the completed project, implementing additional requirements prior to seeking reimbursement and, for public policy reasons in some cases, foregoing recovery of amounts otherwise reimbursable to the state agencies. The agencies took these actions over time, and it was not until the end of fiscal 2001 that it became evident that the entire $15.4 million of accounts receivable would not be realized.

As a result of the implementation of SAB 101, the Company was required to report in subsequent periods the amount of revenue (if material to income before income taxes) recognized in those periods that was included in the cumulative effect adjustment. The Company's footnote disclosure in our previously issued financial statements subsequent to the change in revenue recognition policies did not properly distinguish between amounts that were ultimately billed as revenue and amounts that were determined not to be collectable and accordingly not included in revenues.

16. Quarterly Financial Data (unaudited)

The table below summarizes the Company's unaudited quarterly operating results for its last two fiscal years.

(in thousands, except per share amounts) Year ended December 31, 2004	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Revenue	$ 19,327	$ 21,326	$ 21,292	$ 23,248
Operating income (loss)	(333)	1,084	1,385	5,367
Net income (loss)	(273)	1,142	1,468	5,374
Basic net income (loss) per share	(0.01)	0.06	0.08	0.28
Diluted net income (loss) per share	(0.01)	0.05	0.07	0.24
Year ended December 31, 2003				
Revenue	$ 17,758	$ 17,016	$ 18,708	$ 20,879
Operating income (loss)	(492)	(961)	1,008	2,325
Discontinued operations, net	-	-	212	-
Net income (loss)	(395)	(902)	1,266	2,379
Basic net income (loss) per share	(0.02)	(0.05)	0.07	0.13
Diluted net income (loss) per share	(0.02)	(0.05)	0.06	0.12

(a) In the third quarter of 2003, the Company's discontinued operation, PSG, recorded income from operations of $212,000 based on the actual results of operations.

(b) In the fourth quarter of 2004, the Company recorded a reduction in bad debt expense of $1.7 million resulting from the settlement of two account receivable from D.C. See Note 3.

HMS HOLDINGS CORP. AND SUBSIDIARIES
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(in thousands)

Allowance for doubtful accounts:

Balance, December 31, 2001	$3,341
Provision	311
Recoveries	16
Charge-offs	(301)
Balance, December 31, 2002	3,367
Provision	300
Recoveries	-
Charge-offs	(206)
Balance, December 31, 2003	$3,461
Provision	(1,395)
Recoveries	47
Charge-offs	(1,247)
Balance, December 31, 2004	$866

HMS HOLDINGS CORP. AND SUBSIDIARIES
EXHIBIT INDEX

Exhibit Number	Description
2	Agreement and Plan of Merger, dated as of December 16, 2002, among Health Management Systems, Inc., HMS Holdings Corp. and HMS Acquisition Corp. (Incorporated by reference to Exhibit 2.1 to Amendment No. 1 ("Amendment No. 1") to HMS Holdings Corp.'s Registration Statement on Form S-4, File No. 333-100521 (the "Form S-4"))
3.1(i)	Restated Certificate of Incorporation of HMS Holdings Corp. (Incorporated by reference to Exhibit 3.1 to Amendment No. 1)
3.1(ii)	Certificate of Amendment to the Certificate of Incorporation of HMS Holdings Corp. (Incorporated by reference to Exhibit 3.1(a) to HMS Holdings Corp.'s Registration Statement on Form S-8, File No. 333-108436 (the "1999 Plan Form S-8")
3.2	By-laws of HMS Holdings Corp. (Incorporated by reference to Exhibit 3.2 to the Form S-4)
10.1	Health Management Systems, Inc. Employee Stock Purchase Plan, as amended (Incorporated by reference to Exhibit 10.2 to the January 1994 Form 10-Q and to Exhibit 10.1 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended January 31, 1995 (the "January 1995 Form 10-Q"))
10.2	Health Management Systems, Inc. 1995 Non-Employee Director Stock Option Plan (Incorporated by reference to Exhibit 10.2 to the January 1995 Form 10-Q)
10.3	HMS Holdings Corp. 1999 Long-Term Incentive Stock Plan (Incorporated by reference to Exhibit 4 to the 1999 Plan Form S-8)
10.3(i)	Form of Incentive Stock Option Agreement (Incorporated by reference to Exhibit 10.1 to HMS Holdings Corp.'s Current Report on Form 8-K dated December 14, 2004 (the "December 2004 Form 8-K"))
10.3(ii)	Form of Non-Qualified Stock Option Agreement (Incorporated by reference to Exhibit 10.2 to the December 2004 Form 8-K)
10.4(i)	Employment Agreement, dated as of October 2, 2000, between Health Management Systems, Inc. and William F. Miller III (Incorporated by reference to Exhibit 10.17(i) to Health Management Systems, Inc.'s Annual Report on Form 10-K for the year ended October 31, 2000 (the "2000 Form 10-K"))
10.4(ii)	Amendment, dated as of November 4, 2003, to Employment Agreement between HMS Holdings Corp. and William F. Miller III
10.5	Restricted Stock Purchase Agreement for 550,000 Common Shares dated January 10, 2001, between Health Management Systems, Inc. and William F. Miller III (Incorporated by reference to Exhibit 10.17(ii) to the 2000 Form 10-K)
10.6	Pledge Agreement, dated January 10, 2001, between Accelerated Claims Processing, Inc. and William F. Miller III (Incorporated by reference to Exhibit 10.17(iii) to the 2000 Form 10-K)
10.7	Promissory note, dated January 10, 2001, in the principal amount of $721,875 between William F. Miller III and Accelerated Claims Processing, Inc. (Incorporated by reference to Exhibit 10.17(iv) to the 2000 Form 10-K)
10.8(i)	Employment Agreement dated as of March 30, 2001 by and between Health Management Systems, Inc. and Robert M. Holster (Incorporated by reference to Exhibit 10.2(i) to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended April 30, 2001 (the "April 2001 Form 10-Q"))
10.8(ii)	Amendment dated as of February 11, 2004 to Employment Agreement between HMS Holdings Corp. and Robert M. Holster (Incorporated by reference to Exhibit 10 to HMS Holdings Corp.'s Quarterly Report on Form 10-Q for the quarter ended March 31, 2004
10.9	Stock Option Agreement dated as of March 30, 2001 by and between Health Management Systems, Inc. and Robert M. Holster (Incorporated by reference to Exhibit 10.2(ii) to the April 2001 Form 10-Q)
10.10	Employment Agreement dated as of January 1, 2003 by and between Health Management Systems, Inc. and William C. Lucia (Incorporated by reference to Exhibit 10.13 to HMS Holdings Corp.'s Annual Report on Form 10-K for the year ended December 31, 2002 (the "2002 Form 10-K"))
10.11	Agreement for Financial Management Services, dated as of April 1, 2003, between

HMS HOLDINGS CORP. AND SUBSIDIARIES
EXHIBIT INDEX

Exhibit Number	Description
	Accordis Inc. and the County of Los Angeles
10.12(i)	Leases, dated September 24, 1981, September 24, 1982, and January 6, 1986, as amended, between 401 Park Avenue South Associates and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.13 to Health Management Systems, Inc.'s Registration Statement on Form S-1, File No. 33-46446, dated June 9, 1992 and to Exhibit 10.5 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended January 31, 1994)
10.12(ii)	Lease, dated as of March 15, 1996, by and between 387 PAS Enterprises, as Landlord, and Health Management Systems, Inc., as Tenant (Incorporated by reference to Exhibit 10.2 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 1996 (the "July 1996 Form 10-Q"))
10.12(iii)	Fifth Amendment, dated May 30, 2000 to the lease for the entire eighth, ninth, and tenth floors and part of the eleventh and twelfth floor between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.1 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended July 31, 2000 (the "July 2000 Form 10-Q"))
10.12(iv)	Sixth Amendment, dated May 1, 2000 to the lease for the entire eighth, ninth, and tenth floors and part of the eleventh and twelfth floor between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. Tenant (Incorporated by reference to Exhibit 10.2 to the July 2000 Form 10-Q)
10.12(v)	Seventh Amendment, dated April 1, 2001 to the lease for the entire eighth, ninth, and tenth floors and part of the eleventh floor between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. Tenant (Incorporated by reference to Exhibit 10.1(v) to the April 2001 Form 10-Q)
10.12(vi)	Third Amendment, dated May 30, 2000 to the lease for a portion of the eleventh floor between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.3 to the July 2000 Form 10-Q)
10.12(vii)	Fourth Amendment, dated May 1, 2000 to the lease for a portion of the eleventh floor between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.4 to the July 2000 Form 10-Q)
10.12(viii)	Fifth Amendment, dated May 1, 2003 to the lease for a portion of the eleventh floor between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.1(vi) to the April 2001 Form 10-Q)
10.12(ix)	Fifth Amendment, dated May 30, 2000 to the lease for the fourth floor and the penthouse between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.7 to the July 2000 Form 10-Q)
10.12(x)	Sixth Amendment, dated May 1, 2000 to the lease for the fourth floor and the penthouse between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.8 to the July 2000 Form 10-Q)
10.12(xi)	Seventh Amendment, dated March 1, 2001 to the lease for the fourth floor and the penthouse between 401 Park Avenue South Associates, LLC and Health Management Systems, Inc. (Incorporated by reference to Exhibit 10.1(iv) to the April 2001 Form 10-Q)
10.13(i)	Sublease Agreement, dated December 23, 1997, between Health Management Systems, Inc. and Shandwick USA, Inc. (Incorporated by reference to Exhibit 10.1 to Health Management Systems, Inc.'s Quarterly Report on Form 10-Q for the quarter ended January 31, 1998 (the "January 1998 Form 10-Q"))
10.13(ii)	Consent to Sublease, dated December 23, 1997, by 387 P.A.S. Enterprises to the subletting by Health Management Systems, Inc. to Shandwick USA, Inc. (Incorporated by reference to Exhibit 10.2 to the January 1998 Form 10-Q)
10.14	Sublease Agreement, dated as of January 2003, between Health Management Systems, Inc. and Vitech Systems Group, Inc. (Incorporated by reference to Exhibit 10.17 to the 2002 Form 10-K)
*10.15	Settlement Agreement and Release dated February 3, 2005 between the District of

HMS HOLDINGS CORP. AND SUBSIDIARIES
EXHIBIT INDEX

Exhibit Number	Description
	Columbia and Health Management Systems, Inc.
*21	List of Subsidiaries of HMS Holdings Corp.
*23	Consent of Independent Registered Public Accounting Firm
*31.1	Rule 13a-14(a)/15d-14(a) Certification of the Principal Executive Officer of HMS Holdings Corp.
*31.2	Rule 13a-14(a)/15d-14(a) Certification of the Principal Financial Officer of HMS Holdings Corp.
*32.1	Section 1350 Certification of the Principal Executive Officer of HMS Holdings Corp. The information contained in this Exhibit shall not be deemed filed with the Securities and Exchange Commission nor incorporated by reference in any registration statement filed by the registrant under the Securities Act of 1933, as amended.
*32.2	Section 1350 Certification of the Principal Financial Officer of HMS Holdings Corp. The information contained in this Exhibit shall not be deemed filed with the Securities and Exchange Commission nor incorporated by reference in any registration statement filed by the registrant under the Securities Act of 1933, as amended.

* Filed herewith.

EXHIBIT 21

HMS HOLDINGS CORP.

LIST OF SUBSIDIARIES

Subsidiary	State Of Incorporation
Accordis Inc. 401 Park Avenue South New York, NY 10016	New York
Health Management Systems, Inc. 401 Park Avenue South New York, NY 10016	New York
Health Receivables Management, Inc. 820 West Jackson Boulevard, Suite 725 Chicago, IL 60607	Delaware
HMS Business Services Inc. 401 Park Avenue South New York, NY 10016	New York
Reimbursement Services Group Inc. 401 Park Avenue South New York, NY 10016	New York

EXHIBIT 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors
HMS Holdings Corp.:

We consent to incorporation by reference in the registration statement (Nos. 333-108436, 333-108445 and 33-95326-99) on Form S-8 of HMS Holdings Corp. of our reports dated March 25, 2005, with respect to the consolidated balance sheets of HMS Holdings Corp. and subsidiaries as of December 31, 2004 and 2003 and the related consolidated statements of income, shareholders' equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2004, and the related financial statement schedule, and management's assessment of the effectiveness of internal control over financial reporting as of December 31, 2004 and the effectiveness of internal control over financial reporting as of December 31, 2004, which reports appear in the December 31, 2004 annual report on Form 10-K of HMS Holdings Corp.

/s/ KPMG LLP

New York, New York
March 25, 2005

Exhibit 31.1

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, William F. Miller III, certify that:

1. I have reviewed this report on Form 10-K of HMS Holdings Corp.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's Board of Directors (or other persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 25, 2005

/s/ William F. Miller III
William F. Miller III
Chairman and Chief Executive Officer

Exhibit 31.2

Certification Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Thomas G. Archbold, certify that:

1. I have reviewed this report on Form 10-K of HMS Holdings Corp.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's Board of Directors (or other persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 25, 2005

/s/ Thomas G. Archbold
Thomas G. Archbold
Chief Financial Officer

Exhibit 32.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER PURSUANT TO 18 U.S.C. SECTION 1350

In connection with the accompanying Annual Report on Form 10-K of HMS Holdings Corp. for the year ended December 31, 2004, I, William F. Miller III, Chairman and Chief Executive Officer of HMS Holdings Corp., hereby certify pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, to the best of my knowledge and belief, that:

(1) such Annual Report on Form 10-K for the year ended December 31, 2004, fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in such Annual Report on Form 10-K for the year ended December 31, 2004, fairly presents, in all material respects, the financial condition and results of operations of HMS Holdings Corp.

/S/ WILLIAM F. MILLER III
WILLIAM F. MILLER III
Chairman and Chief Executive Officer

A signed original of this written statement required by Section 906, or other document authenticating, acknowledging or otherwise adopting the signature that appears in typed form within the electronic version of this written statement required by Section 906, has been provided to HMS Holdings Corp. and will be retained by HMS Holdings Corp. and furnished to the Securities and Exchange Commission or its Staff upon request.

March 25, 2005

Exhibit 32.2

CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER PURSUANT TO 18 U.S.C. SECTION 1350

In connection with the accompanying Annual Report on Form 10-K of HMS Holdings Corp. for the year ended December 31, 2004, I, Thomas G. Archbold, Chief Financial Officer of HMS Holdings Corp., hereby certify pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, to the best of my knowledge and belief, that:

(1) such Annual Report on Form 10-K for the year ended December 31, 2004, fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in such Annual Report on Form 10-K for the year ended December 31, 2004, fairly presents, in all material respects, the financial condition and results of operations of HMS Holdings Corp.

/S/ THOMAS G. ARCHBOLD
THOMAS G. ARCHBOLD
Chief Financial Officer

A signed original of this written statement required by Section 906, or other document authenticating, acknowledging or otherwise adopting the signature that appears in typed form within the electronic version of this written statement required by Section 906, has been provided to HMS Holdings Corp. and will be retained by HMS Holdings Corp. and furnished to the Securities and Exchange Commission or its Staff upon request.

March 25, 2005

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2005

[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission File Number: 0-50194

HMS HOLDINGS CORP.
(Exact name of registrant as specified in its charter)

New York	**11-3656261**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer) Identification No.)
401 Park Avenue South, New York, New York	**10016**
(Address of principal executive offices)	(Zip Code)

(212) 725-7965
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act: None
Securities registered pursuant to Section 12(g) of the Act:
Common Stock
(Title of Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes [ ] No [X]

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 of the Act. [ ]

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes [X] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [X]

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer [ ] Accelerated filer [X] Non-accelerated filer [ ]

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).

Yes [ ] No [X]

Aggregate market value of voting stock held by non-affiliates as of June 30, 2005 was $127 million.

The approximate aggregate market value of the registrant's common stock, $0.01 par value, held by non-affiliates (based on the last reported sales price on the Nasdaq National Market) was $158.5 million at March 9, 2006.

The number of shares common stock, $0.01 par value, outstanding as of March 9, 2006 was 20,995,148.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the Annual Meeting of Shareholders to be filed pursuant to Regulation 14A on or before April 30, 2006 are incorporated in Part III of this report.

HMS HOLDINGS CORP. AND SUBSIDIARIES

ANNUAL REPORT ON FORM 10-K

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Special Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K contains "forward-looking" statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. For this purpose any statements contained herein that are not statements of historical fact may be deemed to be forward-looking statements. Without limiting the foregoing, the words "believes," "anticipates," "plans," "expects" and similar expressions are intended to identify forward-looking statements. These statements involve unknown risks, uncertainties and other factors, which may cause our actual results to differ materially, from those implied by the forward looking statements. Among the important factors that could cause actual results to differ materially from those indicated by such forward-looking statements include those risks identified in "Item 1A –Risk Factors" and other risks identified in this Form 10-K and presented elsewhere by management from time to time. Such forward-looking statements represent management's current expectations and are inherently uncertain. Investors are warned that actual results may differ from management's expectations.

PART I

Item 1. Business

Overview

HMS Holdings Corp. (Holdings or the Company) provides a variety of cost containment and payment accuracy services relating to government healthcare programs. These services are generally designed to help our clients increase revenue and reduce operating and administrative costs. They are offered through our Health Management Systems, Inc. (HMS) and Reimbursement Services Group Inc. (RSG) subsidiaries.

HMS, which generates approximately 85% of Holdings' revenue, works on behalf of government payors to help contain healthcare costs by recovering expenditures that were the responsibility of a third party, or were paid in error. HMS's customers are state and county Medicaid programs, Medicaid managed care plans, child support enforcement agencies, state prescription drug plans and other public programs.

RSG, which generates approximately 15% of Holdings' revenue, works on behalf of large public, voluntary and for profit hospitals to document services that qualify for reimbursement through Medicare cost reports and other government payment mechanisms.

During 2005, the Company sold its Accordis Inc. (Accordis) subsidiary, which in prior periods had been a separate reportable segment. The historical operating results of Accordis have been reported as discontinued operations for all periods presented.

The Healthcare Environment

In 2005, the nation's healthcare reimbursement system in which the Company operates continued to grow more complex, creating new regulatory and economic pressures for healthcare payors and providers. Much of this complexity involved changes within Medicare, the federal healthcare program for the elderly, as it prepared to implement its much-publicized prescription drug benefit. In addition, 2005 saw increasing scrutiny and reform of the complex process by which government compensates providers through Medicaid, the federal/state healthcare program for low income Americans.

Such complexity is compounded by the structure of healthcare payors and their reimbursement systems. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health & Human Services, while the Medicaid program is regulated by CMS but administered by

state healthcare agencies. Medicare and many state agencies rely on contracted fiscal agents to process claims for reimbursement. Many beneficiaries of both Medicare and Medicaid are enrolled in managed care plans, to which responsibility for both patient care and claim adjudication has been delegated. The specific requirements and protocols for reimbursement differ among fiscal agents and among states. In addition, health insurance companies and self-insured employers have their own procedures for claim reimbursement, which differ from state to state and region to region. The result is a continually evolving and expanding maze of requirements for healthcare reimbursement.

Because Holdings' services help clients determine appropriate Medicare and Medicaid reimbursement, we are subject to some of the same federal and state requirements that govern our clients' interactions with these programs. Primarily, the regulations pertain to billing for healthcare services, fraud prevention, privacy and record-keeping. Our company operates in a manner that is consistent with these regulations, and we are aware that violating them could adversely affect our business.

A regulation with significant impact on our company and our clients has been the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which created national standards for conducting certain types of electronic healthcare transactions and for safeguarding the integrity and confidentiality of health information. Holdings is required to meet HIPAA standards that are comparable to those of our Medicare and Medicaid clients, and we have worked diligently to anticipate and attain these standards.

Specifically, over the past several years we have achieved full compliance with the HIPAA requirement for Transaction and Code Set Standards as well as the Privacy Regulation. And most recently, we attained full compliance with the HIPAA Standard for Data Security --the final component of the regulations-- in advance of the April 21, 2005 deadline. Holdings also has expanded its use of internal and external auditing functions to ensure that we continue to meet rigorous quality standards such as these.

In 2005, government agencies, commercial health insurers, and other healthcare entities prepared for the full implementation of the Medicare Modernization Act – particularly the Part D prescription drug benefit, which was scheduled to take effect January 1, 2006. However, it appears that the benefit may burden state healthcare agencies with significant new costs and responsibilities. In addition, by adding additional payors to the variety of entities that cover healthcare costs, and by overlaying a very complex coinsurance formula on pharmacy claims, the Part D benefit may increase the difficulty of coordinating benefits. Indeed, as 2005 drew to a close, CMS and state Medicaid agencies grappled with new rules and procedures – some of which were not yet finalized – for sharing drug costs appropriately.

At the same time, however, the federal government has begun taking action that may improve the process through which healthcare costs are shared. Congress introduced legislation in 2005 that, if enacted, will better arm state Medicaid agencies to recover costs for which other payors are liable. President Bush and Secretary of Health & Human Services Michael O. Leavitt pledged to implement new measures that would drive out an estimated $60 billion in fraudulent and wasteful Medicaid costs over the next 10 years.

In 2005, CMS also continued to advance a new approach to managing Medicaid data – an approach that ultimately may streamline program administration, improve outcome quality, and enhance cost efficiency. The Medicaid Information Technology Architecture (MITA) will require program agencies and vendors to integrate data across the Medicaid enterprise, using open, standards-based systems. The initiative already serves as the foundation for the Iowa Medicaid program, and other states are adopting MITA principles in their own programs.

Principal Products And Services

HMS

HMS provides cost containment services to government healthcare programs and the health plans with which they contract for member benefits. To date, HMS has recovered a total of more than $3 billion in inappropriate expenditures for its clients, a milestone we surpassed in July 2005 – less than two years after exceeding $2 billion in recoveries. In addition, the health insurance information we have provided our clients has allowed them to cumulatively save a total of more than $4 billion.

The demand for HMS's services stems from the nation's vastly expensive multi-payor healthcare system, and the sometimes-conflicting rules that determine the liability of payors and the reimbursement for specific services. Because of the complexity of this system and administrative error, government programs often pay more than the appropriate amounts.

Medicaid, for example, is by law the "payor of last resort," covering the cost of care that other healthcare benefits do not. For this reason, the Federal government requires that states attempt to recover payments made on behalf of beneficiaries with other health insurance. Since 1985, HMS has provided state Medicaid agencies with coordination of benefits (COB) services to identify the other parties with liability for Medicaid claims. We subsequently began providing these services to Medicaid health plans, and more recently, we have offered COB services to the Medicare program and its health plans.

Our COB services draw on our proprietary information management techniques, and a methodology that generally includes the following steps:

- Identification
  We match client data to benefit eligibility files we obtain from other parties, including Medicaid, Medicare, commercial insurers, HMOs, third party administrators, TRICARE, and others. This process identifies other potentially liable payors.

- Validation
  After identification of potential liability, we validate our findings by confirming coverage for specific benefits. We employ a highly trained team of verification specialists and automated technology to perform this function.

- Recovery
  When we confirm that eligibility and coverage were in effect for a member and related episode of care, we pursue recovery of the payment from the liable party. Usually, we recover payment through direct billing of insurers or disallowance of overpayments to the healthcare provider. Occasionally, we recover payments by negotiating a settlement with the other party.

- Cost Avoidance
  Once we verify the other coverage or receive claim payment from the liable party, we electronically submit this coverage information to our clients. The data is used to avoid paying similar claims for the member in the future.

In addition to our COB services, we use a variety of auditing and information management techniques to help clients identify and recover other types of inappropriate payments – for example, duplicate payments, payments that are made on behalf of a deceased beneficiary, or payments that result from fraud and abuse.

RSG

Our reimbursement services ensure that healthcare providers correctly document services which qualify for special reimbursement through the Medicare Cost Report.

Coinsurance and deductible balances constitute a significant and growing component of Medicare reimbursement. The Federal government recognizes that these balances often remain uncollected, and allows for a cost report adjustment to claim these amounts as bad debt expense; however, the reporting requirements are very demanding. Our Medicare Bad Debt reporting service accurately documents qualifying balances and assists clients in supplying all documentation required for governmental audit.

Since 1986, Medicare has allowed hospitals serving a disproportionate share of low-income patients to claim additional Federal reimbursement to offset the expense of serving this population. Again, the reporting requirements are significant, and require an increasing amount of reconciliation between the hospital's own records and government systems. Our Disproportionate Share reporting service assists hospitals in qualifying for incremental reimbursement under this program, through the Medicare cost report related filings and professional support during audits.

Customers

Traditionally, HMS' customers have consisted of Medicaid and other state-administered programs. However, as states have increased their use of contracted health plans, our business has evolved to serve these entities as well. More recently, HMS has begun offering its services to Medicare, Medicare Advantage plans, Medicare prescription drug plans, and other federal programs and contractors.

In most cases, our customers pay HMS contingency fees calculated as a percentage of the amounts recovered, or fixed fees for a specific volume of cost avoidance data. Most of our contracts have terms of roughly three to four years. At the conclusion of 2005, we held contracts with 25 states and 12 health plans. Generally, contracts may be terminated by either party with notice and provide for a wind-down period.

RSG's clients are generally hospitals with large Medicare and Medicaid populations. We believe that there are approximately 1,000 such facilities in our target market of which 138 are current clients of RSG. We engage in both multi-year and short-term engagements with our clients and substantially all of the engagements provide for contingent fees calculated as a percentage of the amounts recovered or collected for the client. Additionally, a number of our engagements also provide for non-refundable implementation fees due to the significant costs incurred in engagement start-up. The life cycle of a single project can last several years due to the complexities of Medicare cost reporting and the timing of required audits by fiscal intermediaries.

The Company's largest client is the Florida Agency for Health Care Administration. This client accounted for 15%, 14% and 11% of the Company's total revenue in the years ended December 31, 2005, 2004 and 2003, respectively. The Company provides services to this client pursuant to a contract awarded in November 2001 for a three-year period with a three-year renewal through October 2007. The Company's second largest client is the Ohio Department of Jobs and Family Services. This client accounted for 14%, 14% and 17% of the Company's total revenue in the years ended December 31, 2005, 2004 and 2003, respectively. This contract ended in June 2005, although HMS will continue to provide services to this client through June 2006 through a one-year run-out contract amendment. The Company's third largest client is the New Jersey Department of Human Services. This client accounted for 10%, 14% and 10% of the Company's total revenue in the years ended December 31, 2005, 2004 and 2003, respectively. The Company provides services to this client pursuant to a contract awarded in March 2001 for a three-year period with renewals through September 2006. This customer has been a client of the Company since 1985. The loss of any one of these contracts including the contract with the Ohio Department of Jobs and Family Services that will end in June 2006 would not have a material impact upon the Company's financial position or results of operations.

The clients constituting our ten largest clients change periodically. The concentration of revenue in such accounts was 71% of our revenue in the fiscal years ended December 31, 2005, 2004 and 2003. In many instances, we provide our services pursuant to agreements subject to competitive re-procurement. All of these agreements expire between 2006 and 2008. We cannot provide any assurance that any of these agreements will be renewed and, if renewed, that the fee rates will be equal to those currently in effect.

Market Trends/Opportunities

HMS

HMS' business is driven by the nation's vast and expanding healthcare system. The fiscal structure of this system comprises a complex hierarchy of public and private payors, which share expenditures according to difficult and sometimes-conflicting rules. Containing these expenditures presents difficult challenges for government, due to the number and variety of programs at the state and federal level, the unwieldy government appropriations process, and the rise in the cost of care and number of beneficiaries.

In 2004 – the most recent year for which data is available – the nation's healthcare spending totaled $1.9 trillion, according to CMS. This represents an increase of 7.9 percent over the previous year. Healthcare spending also accounted for a much greater portion – 16 percent – of gross domestic product in the United States than in most other countries.

In particular, Medicaid and Medicare spending are fueling this growth. Together, these entitlement programs cost the U.S. more than $760 billion in 2005, and their expenditure growth outpaced that of other public and private programs. Moreover, the growth is expected to accelerate. The federal government estimates that Medicare's prescription drug benefit will add $724 billion to the program's costs over the next decade. And costs for Medicaid – now the single largest and fastest-rising expenditure for state government – have been rising 8-9 percent annually for several years. In 2006, according to the federal budget, Medicaid costs will surpass $338 billion.

For state government, the challenge is compounded by the limitations of their own efforts to contain healthcare costs. After years of fiscal distress, states simply have exhausted much of the opportunity to reign in spending. In addition, the Medicare Modernization Act restricts the ability of states to manage some of their expenditures. While the implementation of the Part D benefit in 2006 will free Medicaid from the cost of certain prescription drugs, states will have to return most of the potential savings back to the federal government. Because they are calculated on the basis of 2003 drug expenditures, these "clawback" payments do not reflect the progress states have made since then in controlling drug costs. Nor can the clawbacks be reduced to reflect any further progress states might make in the future.

As fiscal pressures such as these continue to grow, so too will the need for proper coordination of benefits and the recovery of overpayments. The Office of Management and Budget, the Congressional Budget Office, and other sources estimate that roughly 5 percent of government healthcare costs may be paid inappropriately.. For a healthcare system as large as our nation's, this represents a significant and important opportunity.

RSG

A number of factors are forcing healthcare providers to manage their operations more efficiently. Although the aggregate Medicare and Medicaid funding received by hospitals may be growing, federal and state healthcare cost control initiatives are acting to reduce the proportion of Medicare- and Medicaid-classified hospital charges that are reimbursed by government sources. The eligibility for, and coverage available under, governmental, managed care, and commercial insurance programs is increasingly complex. The rising underinsured and uninsured populations pose a significant challenge especially to public hospitals, which comprise a considerable portion of our client base. With the increasing complexity of the healthcare reimbursement environment and shortages of qualified labor in many areas, it is more and more difficult for an individual provider institution to maintain in-house the

expertise required to properly prepare and submit Medicare Cost Reports. As a result of these pressures providers are now engaging outside technical resources to supplement their in-house expertise.

Competition

HMS

HMS competes primarily with Public Consulting Group, with large public accounting firms, and with small regional firms specializing in one or more of our services. Against these competitors, we typically succeed on the basis of our dominant position in the marketplace, extensive benefit eligibility database, proprietary systems, historically high recovery rates, and pricing.

RSG

RSG competes with large consulting and public accounting firms (most notably Ernst & Young LLP) and with the many regional and local companies that provide reimbursement cost reporting services. We compete on the basis of our Medicare reimbursement program expertise, proprietary technology and systems, existing relationships, long-standing reputation in the market segment, and pricing.

Business Strategy

HMS

Over the course of 2006, we plan to continue growing the HMS business through several strategic initiatives.

Pursue Organic Program Growth. HMS plans to continue to tap demand for services created by the steadily increasing enrollment and per-member expenditures of government-funded healthcare. We believe this demand will be an especially important driver of growth in the managed care arena, as greater portions of the Medicaid and Medicare populations enroll in contracted, risk-bearing health plans or prescription drug plans.

Expand Client Engagements. As we identify new types of cost-containment opportunities for government healthcare, we expect to grow the scope of our engagements with clients. In some cases, this expansion will be incremental, accomplished through value-added services that build upon our ongoing client work. In other cases, we expect these engagements to migrate into full outsourcing relationships, as clients recognize the advantages and economies of scale provided by a comprehensive, "one stop" external resource.

Increase Yield. HMS plans to continue development of tools that will allow us to capture a greater share of potential recoveries. These tools will include innovative technologies that help us identify additional types of erroneous payments, streamline interaction among providers and payors, and speed the flow of client revenue at near-real-time. Should the Deficit Reduction Act become law in 2006, we plan to work with our Medicaid clients to make full use of their new cost recovery powers in order to further increase yield.

Add New Clients. We will work to increase market share by winning contracts with additional Medicaid agencies, other state programs, and Medicaid health plans. We also anticipate bringing federal programs aboard as new clients, as well as Medicare Advantage plans and Medicare prescription drug plans.

Add New Services. We are committed to expanding our menu of services by acquiring or developing new, "bolt-on" services – especially where we see opportunities in the areas of payment accuracy, auditing, and Medicaid subrogation.

RSG

The RSG business strategy is to offer hospitals and other healthcare providers a cost-effective technological solution for properly preparing Medicare cost reports and maximizing allowable recoveries of cost. We utilize a proprietary mainframe based solution that directly interfaces with our client's patient accounting system to identify potential claims that may not be identified by our competitors who principally use consultants and less robust PC-based applications to perform these services.

Employees

As of December 31, 2005, we had 331 employees. No employees are covered by a collective bargaining agreement or are represented by a labor union. We believe our relations with our employees are good.

Financial Information About Industry Segments

Specific financial information with respect to our industry segments is provided in Note 12, Segments and Geographical Information, of the Notes to Consolidated Financial Statements.

Available Information

We maintain a website that contains various information about us and our services. It is accessible at www.hmsholdings.com. Through our website, shareholders and the general public may access free of charge (other than any connection charges from Internet service providers) filings we make with the Securities and Exchange Commission as soon as practicable after filing. Filing accessibility in this manner includes the Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, current reports on Form 8-K and Proxy Statements.

Item 1A. Risk Factors

PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995
SAFE HARBOR COMPLIANCE STATEMENT
FOR FORWARD-LOOKING STATEMENTS

In passing the Private Securities Litigation Reform Act of 1995 (the Reform Act), Congress encouraged public companies to make "forward-looking statements" by creating a safe harbor to protect companies from securities law liability in connection with forward-looking statements. We intend to qualify both our written and oral forward-looking statements for protection under the Reform Act and any other similar safe harbor provisions.

"Forward-looking statements" are defined by the Reform Act. Generally, forward-looking statements include expressed expectations of future events and the assumptions on which the expressed expectations are based. All forward-looking statements are inherently uncertain as they are based on various expectations and assumptions concerning future events and they are subject to numerous known and unknown risks and uncertainties which could cause actual events or results to differ materially from those projected. Due to those uncertainties and risks, prospective investors are urged not to place undue reliance on written or oral forward-looking statements of the Company. We undertake no obligation to update or revise this safe harbor compliance statement for forward-looking statements to reflect future developments. In addition, we undertake no obligation to update or revise forward-looking statements to reflect changed assumptions, the occurrence of unanticipated events or changes to future operating results over time.

We provide the following risk factor disclosures in connection with our continuing effort to qualify our written and oral forward-looking statements for the safe harbor protection of the Reform Act and any other similar

safe harbor provisions. Important factors currently known to management that could cause actual results to differ materially from those in forward-looking statements include the following:

Our Operating Results Are Subject To Significant Fluctuations Due To Variability In The Timing Of When We Recognize Contingency Fee Revenue And Other Factors. As A Result, You Will Not Be Able To Rely On Our Operating Results In Any Particular Period As An Indication Of Our Future Performance.

Our revenue and consequently our operating results may vary significantly from period to period as a result of a number of factors, including the loss of customers, fluctuations in sales activity given our sales cycle of approximately three to eighteen months, and general economic conditions as they affect healthcare providers and payors. Further, we have experienced fluctuations in our revenue of up to 25% between reporting periods due to the timing of periodic revenue recovery projects and the timing and delays in third-party payors' adjudication of claims and ultimate payment to our clients where our fees are contingent upon such collections. The extent to which future revenue fluctuations could occur due to these factors is not known and cannot be predicted. As a consequence, our results of operations are subject to significant fluctuations and our results of operations for any particular quarter or fiscal year may not be indicative of results of operations for future periods. A significant portion of our operating expenses are fixed, and are based primarily on revenue and sales forecasts. Any inability on our part to reduce spending or to compensate for any failure to meet sales forecasts or receive anticipated revenues could magnify the adverse impact of such events on our operating results.

The Majority Of Our Contracts With Customers May Be Terminated For Convenience

The majority of our contracts with customers are terminable upon short notice for the convenience of either party. Although to date none of our material contracts have ever been terminated under these provisions, we cannot be assured that a material contract will not be terminated for convenience in the future. Any termination of a material contract, if not replaced, could have a material adverse effect on our business, financial condition and results of operations.

We Face Significant Competition For Our Services

Competition for our services is intense and is expected to increase. Increased competition could result in reductions in our prices, gross margins and market share. We compete with other providers of healthcare information management and data processing services, as well as healthcare consulting firms. Some competitors have formed business alliances with other competitors that may affect our ability to work with some potential customers. In addition, if some of our competitors merge, a stronger competitor may emerge.

Current and prospective customers also evaluate our capabilities against the merits of their existing information management and data processing systems and expertise. Major information management systems companies, including those specializing in the healthcare industry, that do not presently offer competing services may enter our markets. Many of our competitors and potential competitors have significantly greater financial, technical, product development, marketing and other resources, and market recognition than we have. As a result, our competitors may be able to respond more quickly to new or emerging technologies, changes in customer requirements and changes in the political, economic or regulatory environment in the healthcare industry. In addition, several of our competitors may be in a position to devote greater resources to the development, promotion, and sale of their services than we can.

Simplification Of The Healthcare Payment Process Could Reduce The Need For Our Services

The complexity of the healthcare payment process, and our experience in offering services that improve the ability of our customers to recover incremental revenue through that process, have been contributing factors to the success our service offerings. Complexities of the healthcare payment process include multiple payors, the coordination and utilization of clinical, operational, financial and/or administrative review instituted by third-party payors in an effort to control costs and manage care. If the payment processes associated with the healthcare industry are simplified, the need for our services, or the price customers are willing to pay for our services, could be reduced.

Changes In The United States Healthcare Environment Could Have A Material Negative Impact On Our Revenue And Net Income

The healthcare industry in the United States is subject to changing political, economic and regulatory influences that may affect the procurement practices and operations of healthcare organizations. Our services are designed to function within the structure of the healthcare financing and reimbursement system currently being used in the United States. During the past several years, the healthcare industry has been subject to increasing levels of governmental regulation of, among other things, reimbursement rates, certain capital expenditures, and data confidentiality and privacy. From time to time, certain proposals to reform the healthcare system have been considered by Congress. These proposals, if enacted, may increase government involvement in healthcare, lower reimbursement rates and otherwise change the operating environment for our clients. Healthcare organizations may react to these proposals and the uncertainty surrounding such proposals by curtailing or deferring their retention of service providers such as us. See also "Part 1. Item 1. Business – The Healthcare Environment" for additional discussion on this topic. We cannot predict what impact, if any, such proposals or healthcare reforms might have on our results of operations, financial condition or business.

Recently, the General Accounting Office, an investigative arm of Congress, added Medicaid to its list of high risk programs. According to the GAO, states have used various financing schemes to generate excessive federal Medicaid matching funds while their own share of expenditures has remained unchanged or decreased. Also on January 30, 2004, the United States Senate Finance Committee Chairman requested that the HHS, CMS, and OIG respond to a lengthy request for information about vendors that provide contingency fee based revenue maximization or revenue enhancement services to State Medicaid agencies specifically with the intent to increase federal Medicaid reimbursement. This type of service represents a very small portion of the suite of HMS offerings and corresponding revenue streams. We cannot predict what impact, if any, this inquiry might have on our future results of operations, financial condition or business.

Certain Provisions In Our Certificate Of Incorporation Could Discourage Unsolicited Takeover Attempts, Which Could Depress The Market Price Of Our Common Stock

Our certificate of incorporation authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by our Board of Directors. Accordingly, our Board of Directors is empowered, without shareholder approval, to issue preferred stock with dividend, liquidation, conversion, voting or other rights, which could adversely affect the voting power or, other rights of holders of our common stock. In the event of issuance, preferred stock could be utilized, under certain circumstances, as a method of discouraging, delaying or preventing a change in control. Although we have no present intention to issue any shares of preferred stock, we cannot assure you that we will not do so in the future. In addition, our by-laws provide for a classified Board of Directors, which could also have the effect of discouraging a change of control.

We Depend On Our Largest Clients For Significant Revenue, And If We Lose A Major Client, Our Revenue Could Be Adversely Affected.

We generate a significant portion of our revenue from our largest clients. For the years ended December 31, 2005, 2004, and 2003, our three largest clients accounted for approximately 39%, 41% and 37% of our revenue from continuing operations, respectively. Our relationship with one of these customers ended in June 2005 and will produce revenue through June 2006. While we believe that we will be able to replace this revenue with revenue from two new customers added in 2005, if we were to lose another major client, our results of operations could be materially and adversely affected by the loss of revenue, and we would seek to replace the client with new business.

The Level Of Our Annual Profitability Has Historically Been Significantly Affected By Our Third And Fourth Quarter Operating Results.

We typically realize higher revenues and operating income in the last two quarters of our fiscal year. This trend reflects the inherent purchasing and operational cycles of our clients. Although we currently anticipate that our revenue and profit in the third and fourth quarters of 2006 will be greater than comparable amounts for the first and second quarters of 2006, if we do not realize increased revenue in future third and fourth quarter periods, including 2006, due to adverse economic conditions in those quarters or otherwise, our profitability for any affected quarter and the entire year could be materially and adversely affected because ongoing data processing and general and administrative expenses are largely fixed.

We Have Retained Certain Accordis Liabilities And Provided Indemnifications To The Buyer That Could Have A Future Negative Effect On Our Results Of Operations

A major client of Accordis has filed a claim against Accordis for certain alleged processing errors in submitting claims on behalf of the client. In connection with the sale of Accordis, we agreed to indemnify Accordis and its buyer with respect to this claim. See Item 3. Legal Proceedings. As part of the sale, we also agreed to indemnify the buyer for liabilities in connection with Accordis that arose prior to the sale of Accordis on August 31, 2005. The buyer agreed to indemnify us for liabilities in connection with Accordis that arise after the sale. There is a minimum indemnification claim threshold of $250,000 that is computed after taking into account any insurance proceeds. Our liability under the indemnification provisions of the sale agreement is capped at the purchase price. We are not aware of any potential claims under the indemnification provisions of the sale agreements but in the event that any liabilities should arise from these discontinued operations in excess of the amounts recorded, there could be a material impact on our results of operations.

Item 1B. Unresolved Staff Comments

None

Item 2. Properties

Our New York City corporate headquarters consists of approximately 81,000 square feet of leased space. In addition, as of December 31, 2005, we lease approximately 103,000 square feet of office space in 13 other locations throughout the United States. See Note 11(b) of the Notes to Consolidated Financial Statements for additional information about our lease commitments.

Item 3. Legal Proceedings

A major client of Accordis has filed a claim against Accordis for certain alleged processing errors in submitting claims on behalf of the client. In connection with the sale of Accordis, we agreed to indemnify Accordis and its buyer with respect to this claim. We believe that the range of loss on this claim is between $0.7 million and $3.5 million and a significant portion of the claim may be covered by insurance. We have had discussions with the client regarding the claim, but we have not yet been able to reach a satisfactory resolution. There can be no assurances that the claim will be settled without material liability to us or that insurance will be available to cover our losses. We have recorded $0.7 million as a liability for this claim.

Other legal proceedings to which we are a party, in the opinion of our management, are not expected to have a material adverse effect on our financial position, results of operations, or liquidity.

Item 4. Submission of Matters to a Vote of Security Holders

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock is included in the Nasdaq National Market (symbol: HMSY). As of the close of business on March 3, 2006, there were approximately 6,000 holders of our common stock, including the individual participants in security position listings. We have not paid any cash dividends on our common stock and do not anticipate paying cash dividends in the foreseeable future. Our current intention is to retain earnings to support the future growth of our business.

The table below summarizes the high and low sales prices per share for our common stock for the periods indicated, as reported on the Nasdaq National Market.

	HIGH	LOW
Year ended December 31, 2005:		
Quarter ended December 31, 2005	$8.10	$6.75
Quarter ended September 30, 2005	8.04	6.56
Quarter ended June 30, 2005	7.90	5.88
Quarter ended March 31, 2005	8.98	7.15
Year ended December 31, 2004:		
Quarter ended December 31, 2004	$9.00	$6.01
Quarter ended September 30, 2004	6.78	5.19
Quarter ended June 30, 2004	6.98	5.26
Quarter ended March 31, 2004	7.49	3.88

Equity Compensation Plan Information

The following table summarizes the total number of outstanding options and shares available for other future issuances of options under all of our equity compensation plans as of December 31, 2005.

Plan Category	*Number of securities to be issued upon exercise of outstanding warrants, options and rights (a)*	*Weighted-average exercise price of outstanding warrants, options and rights (b)*	*Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a) (c)* [2]
Equity Compensation Plans approved by Shareholders [1]	3,672,462	$4.02	321,115
Equity Compensation Plans not approved by Shareholders [3]	1,450,000	$1.25	-
Total	5,122,462	$3.24	321,115

(1) This includes options to purchase shares outstanding: (i) under the 1999 Long-Term Incentive Plan, (ii) the 1995 Non-Employee Director Stock Option Plan, and (iii) 250,000 options approved by shareholders and granted to a director in June 2002.

(2) Of these shares: (i) 247,615 shares remain available for future issuance under our 1999 Long-Term Incentive Plan, and (ii) 73,500 shares remain available for issuance under the 1995 Non-Employee Director Stock Option Plan.

(3) Options issued under plans not approved by the shareholders include (i) 750,000 options granted in January 2001 to our Chairman and former Chief Executive Officer in connection with his joining us, and (ii) 700,000 options granted in March 2001 to our Chief Executive Officer in connection with his joining us.

Issuer Purchases of Equity Securities

On May 28, 1997, the Board of Directors authorized the Company to repurchase such number of shares of our common stock that have an aggregate purchase price not to exceed $10 million. During the year ended December 31, 2003, we repurchased 35,800 shares for $104,000. During the year ended December 31, 2005, we repurchased 17,930 shares for $109,000. At December 31, 2005, $0.6 million remains authorized for repurchases under the program.

Item 6. Selected Financial Data

SELECTED CONSOLIDATED FINANCIAL DATA (see Notes)

(In Thousands, Except Per Share Data)

	Years ended December 31,				
	2005	2004	2003	2002	2001
Statement of Operations Data:					
Revenue	60,024	50,451	42,823	35,251	31,384
Cost of services	52,448	45,327	41,562	39,498	44,171
Operating income (loss)	7,576	5,124	1,261	(4,247)	(12,787)
Gain on sale of assets	-	-	-	-	1,605
Net interest and net other income	1,238	313	250	521	679
Income (loss) from continuing operations before income taxes	8,814	5,437	1,511	(3,726)	(10,503)
Income tax expense	465	103	35	-	-
Income (loss) from continuing operations	8,349	5,334	1,476	(3,726)	(10,503)
Discontinued operations:					
Income (loss) from discontinued operations, net	839	2,377	872	4,661	(10,348)
Estimated loss on disposal of discontinued operations, net	(1,161)	-	-	-	(200)
Gain on sale of discontinued operations, net	-	-	-	-	1,587
Income (loss) from discontinued operations	(322)	2,377	872	4,661	(8,961)
Net income (loss)	$ 8,027	$ 7,711	$ 2,348	$ 935	$ (19,464)
Per Common Share Data:					
Basic income (loss) per share:					
From continuing operations	$ 0.42	$ 0.28	$ 0.08	$ (0.20)	$ (0.59)
From discontinued operations	(0.01)	0.12	0.05	0.25	(0.50)
Total	$ 0.41	$ 0.40	$ 0.13	$ 0.05	$ (1.09)
Weighted average common shares, basic	19,865	19,074	18,330	18,199	17,857
Diluted income (loss) per share:					
From continuing operations	$ 0.37	$ 0.24	$ 0.07	$ (0.20)	$ (0.59)
From discontinued operations	(0.01)	0.11	0.05	0.25	(0.50)
Total	$ 0.36	$ 0.35	$ 0.12	$ 0.05	$ (1.09)
Weighted average common shares, diluted	22,287	22,275	20,132	18,199	17,857